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Do All “Good Mothers” Breastfeed? How African American Mothers’ Values and Experiences of Early Motherhood Influence Their Infant Feeding Choices

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Do All “Good Mothers” Breastfeed?

How African American Mothers’ Values and Experiences of Early Motherhood

Influence Their Infant Feeding Choices

by

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
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DEDICATION

My deep gratitude goes first to my committee--and particularly to my advisor Dr. Roberta Baer--for providing years of support, guidance and wisdom. “Thank you” does not seem like a big enough phrase, but I mean it sincerely.

Thanks also to Mom, Jade, and Nikki for always being in my corner and believing in me when I did not. Thanks to my family for instilling in me a personal sense of excellence, commitment and a high value of education at a young age. You helped to create the foundation for this work.

I dedicate this to my children who inspire me every day to be a good mother and to my dear husband who (despite the time and effort spent birthing this work) continues to love me anyway.
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ABSTRACT

The food an infant is fed can reflect many things: a source of nutrition, the social and cultural circumstances into which an infant is born, or even a family’s beliefs about the body and breast milk as a source of nutrition. Exclusive breastfeeding, currently the gold standard for infant feeding in the United States (US), is often identified as an expectation in discourses on being a “good mother.” African American mothers in particular are the least likely group in the US to breastfeed in any capacity and many efforts are underway to increase the breastfeeding rates of this population.

This dissertation presents findings of a three-part qualitative study whose purpose was to examine how African American mothers define being a good mother and to learn what factors they experience in early motherhood that may influence their decisions for infant feeding and infant care. Because most research in this area focuses on low income African American mothers, this research has a distinct focus on middle class African American mothers to allow for the consideration of factors besides low socioeconomic status that may contribute to breastfeeding behavior. By defining good motherhood in accordance with middle class African American mothers’ definition, this research argues against the standard that aligns “good motherhood” with breastfeeding and suggests instead that, in some instances, being a good mother means caring and providing for the family at the exclusion of breastfeeding. Included are suggestions for alternative strategies that extend beyond educating and encouraging African American mothers to conform to a standard that can appear to be in conflict with their primary values.
CHAPTER ONE: INTRODUCTION AND THEORETICAL FRAMEWORK

The role of eating fulfills a basic need of obtaining nutrients key to survival. However, among humans, eating has been argued to impart a number of symbolic and social characteristics that extend beyond meeting the need for physical sustenance (Pelto et al. 2000). The intersection of the biological needs that eating fulfills with the social and cultural factors it offers have been of interest to anthropologists, particularly those who study nutritional anthropology. Within the realm of eating, infant feeding behavior can be a reflection of how the mother and, in some cases, how the infant’s family embodies breastfeeding and infant formula use (Amir 2011). For African American families in particular, in addition to being a source of nutrition, the type of infant food chosen is often an expression of the social and cultural circumstances into which an infant is born. Additionally, it also can reflect the family’s beliefs about the body and breast milk as a source of nutrition.

Around the world, mothers tend to be responsible for determining how an infant is fed, which is weighed into society’s determination of whether or not she is a “good mother” (Liamputtong 2011). The practice of being a good mother is commonly defined at multiple levels and is often rooted in what is termed intensive mothering (Hays 1996). Margaret Mead tells us: “Primitive materials… give no support to the theory that there is a ‘natural’ connection between conditions of human gestation and delivery and appropriate cultural practices…. [The] establishment of permanent nurturing ties between a woman and the child she bears… is dependent upon cultural patterning” (Mead 1962: p. 54). Despite this insight, a prominent contemporary model of parenting known as “intensive mothering” (Hays 1996) places mothers at
the center of its definition of how to be a good parent. Hays (1996), who coined the phrase “intensive mothering,” uses the above quote from Margaret Mead to substantiate her argument that it is untrue that mothers are naturally or ideally suited to take primary responsibility for raising children. She cites an anthropological survey conducted by Weisner and Gallimore (1977) of 186 contemporary cultures in which mothers are the primary caretakers of children in only 20% of families. Instead, she points to a shared effort between women and older children in the raising of small children (Hays 1996, p. 20) as being the most common model worldwide for raising children. The notion of mothers being the person best suited to raising children, Hays (1996) argues, is a social construction rather than one rooted in nature or physiology. She describes intensive mothering to be a model of increasing intensification of child rearing, with none of the items considered crucial to child rearing to be a necessity for raising children (Hays 1996). It is a model that has grown in popularity in recent years, but its adoption is mostly limited to middle class, White mothers in the US (Hays 1996; Roberts 1997). As such, it is a model that is culturally bound to western definitions of motherhood without being adopted universally.

The intensive mothering model of parenting has since been well documented (Blair-Loy 2003; Bobel 2002; Garey 1999; Stone 2007). The practice of intensive mothering identifies children as being precious and priceless, and as a model it encourages mothers to center parenting efforts around the needs of their children, however expensive and demanding meeting those needs might be (Hays 1996). The tenants of the intensive mothering ideology tend to be a means of also defining what a “good mother” is and does. According to Hays (1996), a good mother is expected to teach her children to be responsible and self-reliant adults while simultaneously providing for her children, protecting them and putting their needs first. In order
to fulfill this definition of being a good mother, it is expected that the mother will sacrifice her
own needs, her time and in some cases her values when being a good mother conflicts with this
role (Hays 1996). Likewise, intensive mothering is an ideology defined by mothers who are
caregivers above all else, and who sacrifice great amounts of time, money, energy and emotional
labor towards their end of intensively raising their children (Elliott, Powell and Brenton 2015).

Despite being one of many models of parenting available present day, this model of self-sacrifice that focuses on the role of mothers as primary caretakers has taken hold and become identified in Western society as being the best because it is “what children need and deserve” (Hays 1996, p. 21). Because the responsibility for parenting babies in particular often fall on mothers, the discourses that define good parenting tend to put strict criteria on mothers alone.

Consistent with the message of self sacrifice and provision that intensive mothering outlines is a vision of how a good mother feeds her child. One concept that appears to be inseparable from “good motherhood” is the ideology that a good mother breastfeeds her child (Carter 1995; Murphy 1999). The discourse of infant feeding as discussed in the intensive parenting movement also focuses on what is identified at present as the gold standard in the United States (US) and worldwide for good motherhood: exclusively breastfeeding a baby (Carter 1995; Murphy 1999).

Mothers may find themselves in a “moral minefield” that influences early decisions about how to feed their children (Murphy 1999, p. 205). Discourse about good motherhood and infant feeding can include navigating what is referred to as risk consciousness, the ability of a mother to learn the risks associated with various infant feeding methods and to determine how to best minimize or avoid them (Knaak 2010). Mothers who choose to breastfeed assume the risks of this choice, and mothers who do not breastfeed assume the risks of not breastfeeding. Knaak
(2010) clarifies that the risk discourse of breastfeeding is less about the physical effects and more about the moral implications, broader ideologies and emotions associated with cultural definitions of being a “good mother.” Marshall, Godfrey and Renfry (2007) argue that women face a number of contradictions when it comes to infant feeding and that, despite breastfeeding being a normal imperative for infant health, breastfeeding women are rarely seen in public in western countries where rates are low, which speaks to a different type of risk associated with infant feeding. New mothers may lack embodied knowledge and may lack the confidence that often accompanies experience, which may result in reduced attempts to breastfeed or mothers switching to infant formula use, an option that is considered to be less risky or controversial (Marshall, Godfrey and Renfry 2007).

However, it has been argued that the concept that breastfeeding as synonymous with “good mothering” is actually contested by some groups (Knaak 2010). This argument is supported by other research as well (Elliot et al. 2015; Carter and Anthony 2015; Marshall et al. 2017; Owens et al. 2018; Roberts 1997). Scientists have documented instances in which mothers across various groups, despite racial/ethnic background or social class, experience the intense pressure to conform to the standards of the intensive mothering or “good motherhood” ideologies (e.g., Blair-Loy, 2003; Hays, 1996; McCormack, 2005). Hays (1996) and Roberts (1997) tell us that intensive mothering is coded as “White” and “middle class.”

There has been some examination of other ethnic groups’ perspective of intensive mothering. For instance, Elliott, Powell and Brenton (2015) conducted a study of sixteen low-income, Black single mothers, mothers who have largely been identified as “bad mothers” (Collins 2000; Hays 1996; Luker 1996). They found that these Black mothers embraced this parenting ideology, despite lacking larger social supports and facing structural barriers that make
it difficult to confirm that they are, in fact, good mothers. The research team also found that the mothers rarely felt that they did enough for their children because they were unable to provide opportunities such as private tutoring or music lessons, which are recognized culturally by the mainstream as forms of child cultivation (Elliott, Powell and Brenton 2015).

Similarly, Carter and Anthony (2015) examined concepts of motherhood and the relationship to infant feeding among Black mothers in the US. They found that one third of mothers consider breastfeeding to be a gold standard that is essential for “good mothers” while the remaining two thirds view breastfeeding as “extraordinary mothering” and associate it with exceeding the expectations of being a good mother (Carter and Anthony 2015). This difference between how White and Black mothers consider to be essential for good motherhood can be an important contributor to why White mothers are more likely to be considered “good” while Black mothers are more likely to be considered “bad” (Collins 2000; Hays 1996; Luker 1996).

While many mothers do ascribe to this standard, the attainment of “good motherhood” as defined by intensive mothering is often inhibited by cultural variation in the definitions of the term. Disparities in breastfeeding behavior exist across racial and ethnic groups in the US, with African American or Black mothers consistently found to be the least likely to breastfeed their babies. There is, however, even cultural variation within the US census category defined as “Black/African American.” The literature is replete with use of both terms when referring to those of African descent living in the United States, and they are used interchangeably. “Black” is a broad term that refers to people who present with specific phenotypic characteristics but it is not specifically able to refer to a language, history, belief system, heritage or any other tenants that anthropologists describe as being shared among members of a cultural group. The term “African American” refers to a cultural group with a unique shared heritage and experience of
Blackness within the continental United States. The shared experiences and beliefs of African Americans are so distinct that those who identify as any other ethnic group often do not identify as African American, even if the group happens to share some phenotypic characteristics. This research focused on mothers within the cultural group African American with the expressed intent of studying a single group in order to better understand the cultural and social influences that may contribute to disparities in breastfeeding rates that may not be shared by other groups in the US who also have Black skin. For the purposes of this research, the terms are used interchangeably, with the term “African American” being of primary use.

Much of the research on what influences infant feeding decisions in African American and Black families is focused on lack of health education among these women due to socioeconomic and environmental factors as primary causes. Education efforts are targeted at low-income Black or African American women with the expressed notion that teaching mothers the benefits of breastfeeding will lead to an increase in breastfeeding rates (Anstey et al. 2017).

This practice oversimplifies a behavior that has its roots embedded in historically, environmentally, socially and culturally influenced factors. Focusing on the mother for breastfeeding or formula feeding an infant puts responsibility solely on her and yet it is defined as empowering or encouraging. However, such an initiative excludes the other factors that can influence the decisions made about how to feed an infant, decisions made by other caretakers, decisions influenced by performance expectations of jobs that do not offer paid maternity leave and many other factors. Discourses on good motherhood that do not examine the realities of the mothers’ experiences and values can produce expectations that mothers feel are unattainable and even disruptive. Educating mothers may be an important part of increasing breastfeeding rates, but it puts the onus squarely on mothers and falls short of acknowledging the many influences
that contribute to the decision of how to feed an infant. Also, focusing efforts on low-income African American mothers fails to acknowledge socioeconomic diversity among this group of women and may miss the opportunity to study and support a segment of the population that educators seek to target.

Breastfeeding can convey profound benefits to mothers and infants, and for this reason it is currently considered by health professionals to be the ideal form of infant nutrition (World Health Organization, 1991). Underlying efforts to educate and encourage African American mothers to breastfeed is an assumption that breastfeeding is a heteronormative practice that should apply to all mothers. Anthropologists have argued against this, not because the benefits of breastfeeding are unfounded. Rather, it has been argued that the assertion that formula feeding imparts inferior health outcomes to babies is questionable (Wolf 2011). Thus, the notion that exclusive breastfeeding should be a gold standard of behavior for all mothers of infants fails to consider the realities of many mother’s values, experiences and capacities given the wider context of a mother’s life and responsibilities. The inability to participate in exclusive breastfeeding or the other normative behaviors of good motherhood can create a sense of blame that Blum (1993) describes as “the straightjacket of traditional gender arrangements” (p. 291).

To address these issues, this dissertation examines how middle class African American mothers (MCAMs) in Tampa Bay define and practice good motherhood. It presents findings of a three-part qualitative study conducted from January to October 2017. The purpose of the study was to examine how African American mothers define and experience early motherhood, to determine how they define being a good mother, to learn what values hold the highest priority while caring for a newborn baby and to understand the specific factors that influence infant feeding decisions and other aspects of caretaking. I utilized Pierre Bourdieu’s cultural and social
capital as a theoretical framework for contextualizing the factors that influence African American mothers’ beliefs, habits, and dispositions with regard to infant care. Because low income mothers are usually studied to the exclusion of other groups, this research also includes a distinct focus on the experiences of middle class African American mothers to allow for consideration of factors besides socioeconomic status that may contribute to breastfeeding behavior.

The findings yield definitions of the values prized by this group, including what it means to be a good mother, a term whose definition proves counter to that postulated by health professionals. By defining good motherhood according to middle class African American mothers, I argue against the model that aligns “good motherhood” with breastfeeding and suggest instead that, in some instances, being a good mother means caring and providing for the family at the exclusion of breastfeeding. I also make a case that complicates the notion that educating mothers alone holds the solution for increasing breastfeeding rates. The discussion and conclusions suggest a novel approach to understanding why African American mothers are the least likely to breastfeed as well as suggesting solutions that take a more inclusive approach than the current model which focuses primarily on educating and encourage African American mothers to conform.

**STATEMENT OF THE PROBLEM**

Breastfeeding is recognized by health professionals as the ideal practice for infant feeding due to the physical and emotional benefits conferred to the mother and infant (World Health Organization 1981), and yet breastfeeding is often not selected by mothers who are capable of so doing. African American mothers are the least likely of the racial groups (as categorized by the US Census Bureau) to breastfeed their infants for reasons that are still only partially understood.
Breastfeeding initiation rates among African American mothers nationwide increased significantly from 36% in 1993-94 to 66% in 2013, but these rates still lag behind those of White mothers, which increased from 62% to 84%, and of Hispanic mothers, which increased from 67% to 83% (McDowell et al. 2008; National Immunization Survey [CDC] 2015). Provision of breastfeeding education is one of the “Ten Steps to Successful Breast Feeding” (World Health Organization [WHO] 1998) and numerous education initiatives have been implemented nationwide, including some in Hillsborough County (see Tampa Bay Breastfeeding Taskforce [TBBT] 2018). But few interventions have resulted in long term, sustainable increases in breastfeeding rates by Black mothers nationwide (Baydar et al. 1997; Caulfield et al. 1998; Gross et al. 1998; Li et al. 1998).

Anthropologists have provided critical insights into infant feeding decisions, arguing that eating strategies are rooted in considerations of “complex factors, including environmental constraints, economic and political conditions, women’s workloads, and cultural beliefs about the nature of children … and food” (Dettwyler 1988). Qualitative researchers have utilized ethnography to demonstrate that instituting short-term programs intent on “improving” infant feeding practices without addressing larger social conditions are ultimately ineffective (Van Esterik 2002). Breastfeeding education tends to focus on mothers as independent operators with approaches that aim to increase self-efficacy and proficiency with breastfeeding (Coombs et al. 1998; Cox & Turnbull 1998; Dennis 1999; Dennis & Faux 1999). However, missing from these interventions are considerations of the larger historical, social and cultural constructs of the communities that mothers embody (Amir 2011; Van Esterik 2002), as well as a context that considers the cultural needs and values of African American mothers (Spencer & Grassley 2013). Also, the majority of studies and interventions focus on low-income, uneducated
mothers. Whether or not this emphasis is due to a widespread assumption that all African American mothers are low-income and not educated, it leaves middle and upper class African American mothers (MCAM) ignored.

A reductionist approach to the issue might be to say simply that all mothers who are good mothers should breastfeed their babies. Missing from this statement is the heart of the true problem, which anthropologists continually contribute to discourses intent on changing mothers’ behavior (Blum 1999; Hausman 2004; Stuart-Macadum and Dettwyler 1995; Van Esterik 2002). Breastfeeding may not be accessible by all mothers, nor does it necessarily hold the same appeal for those with complicated histories and contemporary experiences of the use of their bodies that it holds for those whose experiences are simpler (Blum 1999; Power 1999). Namely, women of color and working class women may be less likely to ascribe to the romanticized notion that breastfeeding at any cost – which for some people could include the risk of losing income that provides for the family, losing relationships, or facing unsettling social conditions that challenge the “normalcy” of this behavior – is their ideal.

With this dissertation, I suggest that these women tend to struggle with the intersection of the normative practices of motherhood and the practices of independent, working women. In a world where women are told they can be all things, the consequence of expecting women to do all things simultaneously results in creating a sense of failure in women instead of creating strength and empowerment. African American mothers may be aware of the benefits that breastfeeding can bring to mother and baby, but they may also consider breastfeeding to require sacrifices that are not easily made. As good mothers, their commitments to meeting their families’ needs often conflict with what it takes to exclusively breastfeed, an issue that requires consideration before any lasting changes can be expected from African American mothers.
THEORETICAL FRAMEWORK: BOURDIEU’S SOCIAL THEORY

WHAT IS BOURDIEU’S SOCIAL THEORY?

In response to Lisa Amir’s editorial on social theory and infant feeding (2011), this dissertation utilized Bourdieu’s theoretical framework of cultural and social capital (Bourdieu 1984; Bourdieu 1985; Bourdieu 1989; Bourdieu & Wacquant 2013) to examine constructs that influence MCAM’s decision-making for infant care, including breastfeeding behavior, and to ultimately explore how they define good mothering. Amir suggests contextualizing breastfeeding within a social structure, recognizing that food and nutrition are about more than nourishing the body (Amir 2011; Fouts, Hewlitt & Lamb 2012). By understanding the influence that our social structures can have on our decisions, we can better understand why education alone is not enough of a strategy for addressing the disparity between breastfeeding rates for African Americans and other racial groups. It also helps us to put into context the significance of breastfeeding as the gold standard behavior for all mothers of infants and to reconsider the appropriateness of this assertion.

Pierre Bourdieu (1930-2002) was a French sociologist who was interested in the ways in which society is reproduced and in the interplay among various social groups that results in a dominant class that strives to maintain its position. He believed this to be about more than economics and discussed the notion that he termed cultural capital in his most famous book, Distinction (1984). Cultural capital is defined as the ways in which people use cultural knowledge to secure their place within society’s hierarchical structure. In Distinction (1984), Bourdieu explores the various elements that signify middle class taste and cultivation, elements that people use to create an identity with social prestige that elevates them to a position “above”
those who they consider to be “below” them. He describes social interactions in this way: “A
general science of the economy of practices that does not artificially limit itself to those practices
that are socially recognized as economic must endeavor to grasp capital, that ‘energy of social
physics’… I have shown that capital presents itself under three fundamental species…economic
capital, cultural capital and social capital.” (Bourdieu and Wacquant 1992; 119). He then
describes social capital as being: “… the sum of the resources, actual or virtual, that accrue to an
individual or a group by virtue of possessing a desirable network of more or less institutionalized
relationships of mutual acquaintance and recognition” (Bourdieu and Wacquant 1992; 119).
This description of social capital offers one explanation for social inequality and the exclusivity
enjoyed by some groups at the expense, in some cases, of those who are not privy to those
resources. And while not the same as economic capital, its value is dependent upon the
individual’s economic capital.

Considering food within a social context resonates with Bourdieu’s study of food and
social class (Bourdieu 1979; Bourdieu 1984). Similar to Pelto and colleagues (2000), he has
argued that food and the act of eating are more significant than simply fueling the body. He
describes eating as an elaborate performance of gender, social class and identity (Warrin et al.
2008). For this reason, it is important to consider the social role of eating and feeding when
examining health behaviors and to recognize the importance of social circumstances in order to
shift any feeding behavior. Bourdieu (1984) explains that cultural norms are inherited from one
generation to the next through a process of socialization. The normative behaviors of the
previous generation become unconscious attitudes and practices for the next generation (Amir
2011). As such, these norms become embodied and are what he describes as habitus.
**Habitus.** At the heart of Bourdieu’s social theory is the concept of habitus, which offers an explanation of the factors that regulate behavior within social structures such as class, gender and ethnicity without being deterministic of behavior (Bourdieu 1984). He explains that habitus is the embodiment of the social structures and the history of an agent, and asserts that those structures which are learned in childhood from our families, our environments and the realities in which we grow up become embodied in the individual. Habitus reflects how an individual agent was taught to perceive the world and forms the basis of the beliefs and actions to which a person compares any future experience. Rather than taking away an individual’s own agency, it is the nature of the structures that shape an individual because each person carries those structures within.

Bourdieu’s conceptualization of social structure suggests that people operate as agents who are defined by their relative position and access to power. He explains that agents interact in a field of power according to the overall capital they hold:

> “These are, principally, economic capital (in its different kinds), cultural capital and social capital, as well as symbolic capital, commonly called prestige, reputation, renown, etc. which is the form in which the different forms of capital are perceived and recognized as legitimate.” (Bourdieu 1985, p. 724.)

Cultural and social capital form the foundation of a person’s social standing and often extend into the symbolic realm. Symbolic capital is defined as the form of power that accompanies social position, which is important for understanding African American women for whom “the general community significantly determines social and economic opportunities and constraints” (Stobenau 2009, p. 2046).
Black women work very hard today to create their political, economic and health standing in today’s environment. According to a report entitled “The Status of Black Women in the United States” (DuMonthier, Childers and Milli 2017), Black women had higher voting rates than other ethnic groups in the past two presidential elections and yet continue to be underrepresented politically. The report (2017) also shows that over 80% of Black women are breadwinners for their families and yet their earnings are still lower than most men and women’s earnings in the US. Additionally, numerous factors contribute to poorer health outcomes for Black women that range from racism to lack to access to quality care to economic insecurity and lack of access to healthy foods (DuMonthier, Childers and Milli 2017). To combat these challenges, Black women may find they work very hard to acquire various forms of capital to improve their social standing.

Whether or not a person realizes it, race influences how cultural capital is experienced and expressed (Wallace 2017). The desire of Blacks to improve standing in society through attainment of various types of capital---identified by one scientist as black cultural capital (Rollock 2015)---creates a means for adopting tastes, behaviors and values that create both class status and racial identity (Wallace 2017). Capital may be so valued that those who have achieved improved social standing may be unwilling to risk anything that challenges it, including behaviors that intensive mothering considers to be essential to being a good mother. For example, if breastfeeding is considered to be a behavior that competes with work hours, that changes the body so that it is less appealing to partners physically, or otherwise decreases the ability to acquire various types of cultural and social capital for African American women, then it may be devalued as a priority despite awareness of its benefits to the health of mothers and babies.
Another example may be that a mother may feel she has a different field of power than her partner or another older female relative in her home environment. In the workplace, she may feel that she operates in a lower field of power compared with her supervisor or even other colleagues who earn more money, have more education or carry a more prestigious job title. In either space, the mother who feels she has less symbolic capital, or a sense that she has less power to negotiate her own decisions, may succumb to others’ suggestions about how to feed her infant, how to raise him or her and other normative notions about what is considered essential to being a good mother.

One application of Bourdieu’s concept of habitus could be that African American mothers’ dispositions on breastfeeding reflect a lack of community exposure to breastfeeding in childhood and among relatives and friends. This might be different if breastfeeding were as common in the US as it is in countries where women often are expected to feed infants freely and in plain sight (Groleau, Sigouin & D’souza 2013), but it is not (Lasinoh Laboratories 2013). Social theory argues that dispositions acquired in childhood operate in a way that is “preconscious and hence not readily amenable to conscious reflection and modification” (Thompson 1991, p. 12-13). Hence, habitus suggests that individuals are likely to reproduce practices that coincide with the historical and social conditions that created them (Power 1999). While habitus may not determine an agent’s behavior, those dispositions which are deeply rooted in an agent’s habitus can shape the framework within which individual behaviors are determined. Bourdieu’s stipulation that habitus is preconscious provides a possible explanation and the root hypothesis herein for why only enacting an education campaign designed to teach mothers about the benefits of breastfeeding may not be sufficient on its own to create lasting change. Any new education acquired after the initial habitus is formed will always be compared to those
preconscious thoughts, requiring that a shift behavior be able to address habits and practice at a deeper level.

Habitus suggests that individual agents carry their lived histories and social structures within the body (Power 1999). Embedded in US history are negative images of Blacks as savages, and modern Black mothers are likely to embody, on some level, fears of being considered as savages for engaging in such naturalistic behavior as breastfeeding (Blum 1999; Power 1999; Golden 1996). It could be hypothesized in this instance that regardless of any education or training, African American women receive on how beneficial breastfeeding is, they may be unlikely to change individual behaviors that challenge these strong and historical social structures. Efforts to increase breastfeeding would have to make a case for how breastfeeding is specifically beneficial to African American mothers without being exploitative, at the very least. At most, structures that continue to exist today would also have to change to make any assurance of individuals’ long term success (Blum 1999; Power 1999; Spencer & Grassley 2013).

According to Bourdieu, structured spaces that are organized around specific forms of capital form a field. Fields are divided into distinct social arenas, each of which has a set of rules, knowledge and forms of capital (Bourdieu 1985). The concept of capital refers to a collection of symbolic elements that one acquires through being part of a particular social group. Elements of shared capital are what distinguishes the group from others by providing a sense of shared identity. If we considered infant feeding as a field, then the various forms of symbolic capital related to infant feeding include breastfeeding and formula feeding. Mothers who breastfeed (MBF) may have a unique identity compared with mothers who formula feed (MFF).

Bourdieu also points out that cultural capital is a major source of inequality and some forms of capital are valued over others (Power 1999). In the arena of infant feeding, breast milk
is considered by health professionals and by some mothers to be the valued commodity. However, middle class African American mothers who may carry as part of their histories the negative images of wet nursing, slavery and ascribe animal-like definitions to breastfeeding may value formula over breast milk. Infant formula may function as a type of symbolic capital to which mothers allocate freedom for themselves and promises of health for an infant. In addition, the ability to afford the cost of infant formula means that a mother has access to a form of capital which may not be accessible to all mothers, which in turn contributes to the accrual of that mother’s symbolic capital (Groleau, Sigouin & D’souza 2013). An African American mother may affiliate social prestige with use of infant formula due to its symbolic capital if she believes that her social status is increased by being a mother who can afford to buy what society has told her is the “best” food for her infant (Amir 2011; Groleau & Rodriguez 2009).

Breast milk, on the other hand, may have a perceived value as capital whose promises and benefits are less reliable than those of formula, or whose benefits are unknown. Understanding these perceptions would help to clarify the confusion created when a physician asks a mother whose baby receives formula, “don’t you want what’s best for your baby?” (Groleau & Rodriguez 2009) and could offer insight into a better way for health practitioners to encourage or support a mother.

Williams connects Bourdieu’s theories on social class differences in perceived effects of food on health through habitus as stated below:

“...whereas the working-classes are more attentive to the strength of the physical (male) body than its shape, and tend to go for products that are both cheap and nutritious, the professionals prefer products that are tasty, health-giving, light and not fattening.” (Williams 1995, p. 593 citing Bourdieu 1984)
This distinction between how social classes value food is echoed in variations of how African American mothers value tenants of being a good mother including breast milk and the act of breastfeeding, which this research sought to better understand. Perhaps lower values of breast milk itself and the act of breastfeeding in African American communities compared with competing values, as well as lacking social and employer support for breastfeeding, are more to blame for low rates than the knowledge of breastfeeding or the intentions of African American mothers for their children. Or perhaps it is the very intention to be a good mother that justifies why the rates are lower among African American mothers. This research was designed to fill in gaps in understanding these values, as well as to ascertain how African American mothers perceive and navigate the world of infant feeding.

**Research Objectives and Dissertation Outline**

There were four primary objectives of this research. The first objective was to identify how middle class African American mothers define being a good mother, learn what good mothers value, and determine how breastfeeding is prioritized in comparison with formula feeding and those other values. The second objective was to understand who influences and supports MCAMs to either breastfeed or bottle feed their infants. The third objective was to understand obstacles that MCAMs perceive to discourage them from initiating or continuing to breastfeed. The fourth objective was to identify models or strategies that successfully support and encourage MCAMs to feed and care for their infants in a way that considers African American mothers’ values for “good motherhood.”

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1 The term “breastfeeding” for the purposes of this research is used to mean (a) the act of feeding an infant by latching him or her onto the woman’s breast, and (b) feeding a baby breast milk from a bottle. The terms “bottle feed” and “formula feed” will be used synonymously and refer to feeding a baby formula or artificial breast milk.
In Chapter One, I review social theory and use it to examine meanings of good motherhood as defined by MCAM enabled the research to take into account African American mothers’ subjective histories and socially determined values that influence mothers to engage in what they believe to be the best behaviors for infant care. Anthropological theoretical approaches and methodologies were uniquely qualified for this research, as they were essential to uncovering the lived experiences and beliefs of MCAM while obtaining clarity on issues that continue to elude some public health researchers. Bourdieu’s social theory has allowed for deeper understanding of the values, beliefs, perceived experiences, and challenges African American mothers face as they navigate motherhood and infant feeding. Additionally, qualitative methods – discussed in greater detail in Chapter Three – enabled direct observation, as well as both structured and spontaneous interactions, and provided the unique opportunity to gain insights that other methodologies would have been likely to miss.

Chapter Two reviews the literature that provides the scientific significance for the study. It introduces nutritional anthropology and offers a brief review of the history, trends and development of an infant feeding “gold standard.” I also review infant feeding rates for African Americans and provide an overview of current efforts to increase these rates, including the national infant feeding objectives. I also summarize reasons that are speculated in the scientific literature for why African American mothers are less likely to breastfeed before detailing some of the problems with the current approaches and then building an argument for the need to understand infant feeding choices within the context of African American culture.

Chapter Three presents the methodology for this dissertation. It begins with a detailed outline of the four primary research questions (RQs), objectives and hypotheses that guide this dissertation. I then explain the three phases of research including data collection methodologies,
inclusion criteria, observation sites, development of the research assessment tool and then explain how the data was analyzed.

Chapter Four presents the research findings from phase I of research, which includes an ethnographic account from public observations of Black and African American mothers of young children in various locations throughout Tampa Bay.

Chapter Five presents the findings from phases II and III of the study. For the second research phase, I interviewed health professionals who work with African American mothers at the end of their pregnancies and during their child’s early infancy. For the third phase, I interviewed African American mothers with at least one child under five years of age. The purpose of the interviews was to learn from African American mothers how they experience and value the tenants of motherhood, and to compare what they value for themselves and their families to what health professionals value for African American families. The data is merged to present the thematic findings across both groups to allow for insights into issues raised by both mothers and health professionals to identify commonalities among these perspectives and differences between them.

Chapter Six, the final chapter, presents a discussion of the research findings and offers the practical implications and conclusions of these findings. I suggest ways to improve the support available to mothers and others who care for infants, including the possibilities that other research has already considered. I then argue for strategies that I believe have merit but are less often considered and also share novel perspectives and insights provided by this research. Ultimately, I explore the contributions this research makes to anthropology and why this research is critical for making any improvements to the health of African Americans through breastfeeding.
The primary purpose of this research was to contextualize African American mothers’ definitions and expectations of good motherhood, including how infant feeding fits into this paradigm, within the realm of race and class. Motherhood as a normative model is based primarily on the ideals and expectations of middle class White women, and it asserts values with the assumption that this model is appropriate for all mothers and families (Stack 1975). This research attempts to build upon the current gold standard for infant feeding by detailing the nuances that are unique to the mothering experiences of African American mothers. Additionally, it examines the broader context in which these mothers make decisions about infant feeding by outlining how they define being a good mother and investigating how those experiences lead to reduced breastfeeding rates compared with middle class mothers of other census groups. It is from this position of understanding that efforts to support African American mothers who choose to breastfeed can be made with the greatest likelihood of creating a sustainable outcome.
CHAPTER TWO: BACKGROUND AND SIGNIFICANCE

Chapter Two reviews the literature that provides the scientific significance for the study. It begins with an introduction to nutritional anthropology and provides a brief history, trends and development of a “gold standard” for infant feeding. It reviews infant feeding rates for African American infants and the current efforts to increase these rates, including the national infant feeding objectives. It then presents reasons from the scientific literature for why African American mothers are less likely to breastfeed before detailing the problems with the current approaches. Finally, I build upon this literature an argument that the infant feeding choices of African American mothers need to be understood within a cultural context.

Pelto and colleagues argue that breastfeeding research is not done by anthropologists but in areas of health education, nursing, nutrition, public health—fields that heavily influence public policy (Pelto et al. 2000). However, they suggest that anthropologists can build upon this research because these fields have not traditionally relied upon qualitative methodologies to understand the nuances of what influences breastfeeding behavior. Anthropologists note the biases built into how breastfeeding is discussed in “Euro-American society” and are able to offer an examination of the broader context within which infant feeding decisions are made.

Because breastfeeding has well documented benefits for both mother and baby, there is great interest in increasing breastfeeding rates among all mothers (Morrell 2017). Great efforts are currently underway to increase rates among African American mothers in the United States in particular that tend to focus on increasing compliance and commitment. Anthropologists have explored the notion that mothers’ experiences of motherhood and infant feeding need to be
reformed and recontextualized so in order to appropriately consider the underlying issues rather than remaining focused on blaming mothers for a lack of compliance (Blum 1993; Blum 1999; Carter 1995; Hausman 2003; Spencer and Grassley 2013; Van Esterik 2002). What has been considered to be a simple issue of lacking education among African American mothers of infants may actually rooted in a quagmire of historical and cultural experiences that created the very outcome for which these mothers are blamed.

I suggest a reframing of breastfeeding behavior from an issue of non-compliance to one of lacking understanding of and support for African American women, as mothers and as working women. I also suggest the need to reconsider the merits of a “gold standard” that appears to suit one segment of the population while leaving the rest to fall short of its place in “good mothering.” In conclusion, I explain why this dissertation research is necessary for obtaining critical insights into understanding how to support African American mothers in infant care.

**Nutritional Anthropology and History of Infant Feeding**

Pelto, Goodman and Dufour (2000) posit that nutritional anthropology as a discipline is “fundamentally concerned with understanding the interrelationships of biological and social forces in shaping human food use and the nutritional status of individuals and populations” (p. 1). This provides the basis for considering the value of examining food choices and its relevance to the eating experiences and health status of both adults and children as created by nutrition. Primarily, the focus is to study the interactions among the various elements that influence food choice and, subsequently, health outcomes. The elements can include the physical environment, social environment, cultural ideals, as well as factors that influence the physical needs of the...
individual (Pelto, Goodman & Dufour 2000). Nutritional anthropology teaches that what a person eats can be as much a product of choice as it can be a product born out of necessity.

When it comes to contemporary choices about infant feeding in the United States, the decisions made for how to feed an infant are born less out of a biological need based upon food availability and are more predicated upon sociocultural beliefs about what is ideal. Before the advent of technology, the easiest and safest food – indeed, the only food – available to babies was human breastmilk. Technology has since allowed for the creation of a life saving artifice, artificial breast milk or infant formula product that mimics the properties contained within breast milk, that could be used in situations where breastmilk was either not available from the mother or not a safe option in the case of sickness. An early examination of infant feeding in Western Europe (Fildes 1986) provides a groundbreaking historical account of infant feeding that attempted to tie together medical texts, religious texts and advice books on child-rearing along with private notes, letters and diaries between 1500 and 1800 (Qureshi and Rahman 2016). Fildes (1986) documented the progression of infant feeding from the early initiation of breastfeeding and the spread of wet nursing to the progressive replacement of breast milk by infant formula. The author posits that the increased reliance upon infant formula is connected to what were contemporary medical recommendations, declarations of the Church, fashionable behaviors of the higher classes and the influence of gender and generational hierarchies in the household. Most significant was the insistence that as European domination spread, changes in infant feeding practices also spread across the rest of the world.

Mothers and Medicine: A Social History of Infant Feeding (Apple 1987) documented a shift from breastfeeding to infant formula feeding in early twentieth century America. Similar to Fildes’ account, Apple (1987) emphasized that medical providers had a role in exhibiting control
over women's comprehension of infant formula by making it so complicated that only doctors could administer breastmilk substitutes. Golden (2001) outlines the replacement of wet-nursing by infant formula, including offering a detailed history of the interrelationship between wet-nurses, those who hired them, medicals doctors, and the often tragic consequences of wet-nurses' own children.

These accounts offer brief insight into the early shifts from breastfeeding, which was common in the United States until the 1930s, to the rise of the use of infant formula between the 1940s and 1970s (Blum 1993). These declines in breastfeeding coincided with the increased medicalization of birth (Apple 1987; Blum 1993; Carter 1995; Fildes 1986; Golden 2001; Palmer 1988; Qureshi and Rahman 2016), as outlined above. Martin (1987) explains that women’s bodies were systematically undermined with regard to the ability to birth babies and then nurture them. The medical industry and political powers encouraged the widespread belief that a scientifically-formulated infant milk product was better than breast milk. According to Martin (1987), the primary consideration in the development of formula was that it could be controlled, regulated, and made safe whereas women's bodies could not. She further describes the efforts to promote infant formula as simultaneously degrading confidence in women’s bodies which in such a way that mothers who used formula became dependent on a trained nurse for the knowledge of how to feed, how to know when her baby was satisfied, and other cues that mothers often manage intuitively (Hausman 2003).

Carter and colleagues (2015) argue that the commoditization of breast milk is another arena undermines women’s confidence in their bodies and challenges their own abilities to manage infant care in the absence of external authority. The authors explain that informal sharing of human breast milk has become a controversial practice (Carter et al. 2015). It is a
common practice and has been recognized as a potentially life-saving practice in some cases (Palmqvist & Doehler 2014). However, research has found contradictory images of human milk that label breast milk donated through a supervised milk bank as “liquid gold” compared with peer shared breast milk, labeled as dangerous, unreliable and potentially life-threatening substance (Carter et al. 2015). It has been argued that such contradictory representations are rooted in high income countries where control and surveillance of the female body are maintained through the discourse of risk rather than celebrating mothers’ agency.

A case is now being made since the widespread advent of infant formula to return to breastfeeding, as scientific research has proven it to offer benefits to both mother and baby (CDC 2014). However, the early efforts outlined above may have served to undermine a mother’s body and her ability to feed her baby while increasing public confidence in infant formula, resulting in what appears to be a chasm that health professionals are working hard to eliminate.

**Breastfeeding as the “Gold Standard”**

Despite campaigns asserted by the medical industry in recent centuries, findings from contemporary research now hold that human breast milk is the best form of infant nutrition. The World Health Organization (WHO) describes breastfeeding as “an unequalled way of providing ideal food for the healthy growth and development of infants” and “a unique biological and emotional basis for the health of both mother and child” (WHO 1981, p. 6). Furthermore, it states that “the anti-infective properties of breast milk help to protect infants against disease” (WHO 1986, p. 6). While its counterpart infant formula contains a number of properties also contained in breast milk, it lacks many of the nutritional contents and beneficial properties within human breast milk (WHO 1981). There are also components to breast milk that are still being discovered and have yet to be replicated by science, such as stem cells and other microbes (Bode
et al. 2014; Hassiotou & Hartmann 2014). There is overwhelming evidence which suggests that breast feeding is the gold standard infant feeding option for babies, providing unparalleled benefits to infants and mothers alike (Walker 2010).

Nationally, breastfeeding has been associated with being nutritionally, immunologically, psychologically, socially, and economically advantageous (US Breastfeeding Committee 2002). The American Academy of Pediatrics (2005), American College of Nurse-Midwives (2004), and American College of Obstetricians and Gynecologists (2003) all have position statements in support of breastfeeding as the optimum infant feeding method. For example, the American Academy of Pediatrics (2005) asserts that “breastfeeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant” (p. 501).

The list of benefits of breastfeeding is extensive. The Agency for Health Research and Quality (AHRQ 2007) discussed the benefits of breastfeeding afforded to mothers and infants. According to the report, early breastfeeding affords protection from global deaths and diseases in children ages 0-5 due to numerous causes, including gastroenteritis, respiratory infection, childhood obesity, diabetes, leukemia and sudden infant death syndrome or SIDS (Ip, et. al 2007). Infants under six months of age who are not breastfed are seven times more likely to die from diarrhea and five times more likely to die from pneumonia than children who are exclusively breastfed, while non-exclusively breastfed infants have only twice the risk (Ip et al. 2007). Additionally, an estimated 13% of 8.8 million deaths worldwide of infants 0-5 months of age are prevented with exclusive breastfeeding, with an additional 6% being prevented with compensatory (breast milk and formula) feeding (Ip et al. 2007). Scientists credit low breastfeeding rates among Black mothers in part for increased obesity among Black children, as breastfeeding has been found to significantly reduce risk (Yan et al. 2014). Scientists also
reported a dose-response effect which indicates that the longer a child is breastfed, the lower the occurrence of childhood obesity (Yan et al. 2014). This finding is significant given the increased rates of childhood obesity and diabetes among Black children (Hess et al. 2015).

The benefits to infants and older children who are breastfed is significant, but benefits do not only extend to children. Mothers who breastfeed have a reduced risk of breast cancer, ovarian cancer, and type 2 diabetes (Ip et al. 2007). Additionally, scientists have found that the longer a mother breastfeeds, the lower her chances of developing breast cancer (Collaborative Group on Hormonal Factors in Breast Cancer 2002). One report suggests that improving breastfeeding rates among Black mothers would also reduce the incidence of basal-like breast cancer among women, given the high rates of this type of breast cancer among Black women (Trevino et. al 2012).

CURRENT EFFORTS TO ENCOURAGE BREASTFEEDING

NATIONAL OBJECTIVES AND INITIATIVES

Because of the overwhelming evidence regarding breastfeeding benefits, many public agencies have set initiatives in motion to bring awareness of the importance of breastfeeding with hopes of increasing breastfeeding rates nationwide. In 2000, the U.S. Surgeon General Dr. David Satcher requested assistance from the Office of Women’s Health, a division of the U.S. Department of Health and Human Services (DHHS), to develop the Blueprint for Action on Breastfeeding, establishing a comprehensive breastfeeding policy for the country (DHHS 2000). This was the first governmental manuscript of its kind to address breastfeeding. Moreover, the United States Breastfeeding Committee (USBC) developed a strategic plan to promote, protect, and support breastfeeding in the nation based on the Maternal, Infant and Child Health (MICH) national objectives developed by DHHS’s Healthy People 2020 program.
Healthy People 2020 set national breastfeeding objectives as follows: 81.9% initiation of breastfeeding among all mothers, 60.6% continuation for at least six months, and 34.1% for one year (Healthy People, 2018). In 2006, these objectives were broadened to incorporate breastfeeding exclusivity (no introduction of solid foods to the infant’s diet) goals (DHHS, 2006). Additional goals were added for exclusive breastfeeding: 46.2% breast feeding exclusivity at 3 months of age and 25.5% at 6 months (see Table 2.1).

<table>
<thead>
<tr>
<th>Objective</th>
<th>2006 Baseline</th>
<th>2020 Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the proportion of infants who are breastfed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever</td>
<td>74.0</td>
<td>81.9</td>
</tr>
<tr>
<td>At 6 months</td>
<td>43.5</td>
<td>60.6</td>
</tr>
<tr>
<td>At 12 months</td>
<td>22.7</td>
<td>34.1</td>
</tr>
<tr>
<td>Exclusively through 3 months</td>
<td>33.6</td>
<td>46.2</td>
</tr>
<tr>
<td>Exclusively through 6 months</td>
<td>14.1</td>
<td>25.5</td>
</tr>
</tbody>
</table>


**BABY FRIENDLY HOSPITAL INITIATIVE**

On a global scale in 1991, the WHO and the United Nations Children’s Fund collaborated to develop the Baby-Friendly Hospital Initiative (BFHI) to promote and recognize hospitals and birthing centers that offer the most advantageous level of care for lactation (BFHI USA 2018). In 1997, the US Healthy Children Project, Inc. undertook the initiative and has created Baby-Friendly USA as the non-profit organization to implement the hospital program nationally (BFHI USA 2018). Merewood and colleagues (2007) studied the effects of a designated Baby-Friendly Hospital on breastfeeding duration where the majority of the sample
was low-income, African American women. The researchers found that at 6 months postpartum, 37% of 248 women were breastfeeding, a rate that was equivalent to the average breastfeeding rate amongst the total U.S. population (36%) at the time study was conducted.

As of January 2018, there are 450 facilities designated as Baby-Friendly Hospitals and Birth Centers in the U.S. According to their website, the goals of BFHI USA are “to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding” and also to “award birthing facilities that successfully implement the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes” (BFHI USA 2018).

Hospitals and their breastfeeding policies play a vital role in whether or not mothers will be successful at breastfeeding. A recent CDC study that examined health outcomes for Blacks living near hospitals found that hospitals in neighborhoods with more Black residents were less likely to meet indicators that support breastfeeding than hospitals in neighborhoods with fewer Black residents (Linde et al. 2014). However, facilities that recommended early initiation of breastfeeding, limited use of formula supplements and encouraged newborns to room with mothers had the greatest success in improving breastfeeding rates among Black mothers. A study of Black women’s experiences at a newly accredited baby-friendly hospital found that developing long-term relationships and alternative methods of support encourage greater breastfeeding success than a brief postpartum education (Miller, Louis-Jacques, Deubel and Hernandez 2018). In addition, findings suggest that there can be racial disparities in access to practices that support breastfeeding.

A number of targeted education campaigns outside of the hospital have also been enacted focused primarily on Black mothers with a few including spouses and other relatives like
grandparents and caretakers. One study found twenty-three education initiatives (Johnson et al 2015). Among the initiatives, the federally mandated Breast Friendly Hospital Initiative was found to create only modest increases in breastfeeding rates of Black mothers within its first ten years of implementation (Grummer and Shealy 2009). One concern is that the initiative takes enormous effort to implement and doing so is incredibly expensive (Phillip et al. 2001; Merewood et al. 2005). The authors noted that other education campaigns have the ability to increase self-efficacy and confidence of mothers, coping skills and breastfeeding technical knowledge even though they cannot address larger social issues (Johnson et al. 2015). However, the need to address wider social issues and to target efforts beyond education efforts for Black mothers was also noted.

**Rates of Breastfeeding Among Black Mothers**

Of primary importance to health researchers are the low initiation and low ongoing breastfeeding rates of Black mothers in the United States.

**Table 2.2: 2014 National Rates of Any and Exclusive Breastfeeding by Race/Ethnicity of Infants**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Any Breastfeeding</th>
<th></th>
<th>Exclusive Breastfeeding (EBF)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initiate Breastfeeding</td>
<td>Breastfed at 6 Mon.</td>
<td>Breastfed at 12 Mon.</td>
<td>EBF for 3 Months</td>
</tr>
<tr>
<td>Hispanic</td>
<td>84.8</td>
<td>52.5</td>
<td>31.7</td>
<td>45.5</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>85.7</td>
<td>60.0</td>
<td>37.8</td>
<td>51.5</td>
</tr>
<tr>
<td><strong>Non-Hispanic Black</strong></td>
<td><strong>68.0</strong></td>
<td><strong>41.5</strong></td>
<td><strong>21.5</strong></td>
<td><strong>32.7</strong></td>
</tr>
<tr>
<td>Non-Hispanic Asian</td>
<td>80.7</td>
<td>61.9</td>
<td>37.5</td>
<td>44.3</td>
</tr>
<tr>
<td>Non-Hisp. Hawaiian/Pacific Islander</td>
<td>79.9</td>
<td>68.1</td>
<td>31.7</td>
<td>59.5</td>
</tr>
<tr>
<td>Non-Hisp. Am. Indian/Alaska Native</td>
<td>79.5</td>
<td>52.8</td>
<td>29.7</td>
<td>51.2</td>
</tr>
<tr>
<td>2 or more races</td>
<td>79.9</td>
<td>53.4</td>
<td>32.8</td>
<td>42.5</td>
</tr>
</tbody>
</table>

Initiation rates have increased across census group categories, but a huge disparity remains between initiation rates of Black mothers compared with Hispanic and White mothers (McDowell 2008). Breastfeeding initiation for Black mothers had reached 66.3% by 2013, but this was significantly lower than breastfeeding rates among White (84.3%) and Hispanic (83%) mothers (NIS 2015; see table 2.2). Breastfeeding rates for Blacks are the lowest across the board compared with other groups.

Socio-Cultural Context of Breastfeeding Behavior Among Black Mothers

Socioeconomic Status (SES) and Education

Research on infant feeding behavior of Black mothers is focused almost exclusively on low income, less educated mothers rather than college educated, middle and upper class mothers (Spencer & Grassley 2013). The available literature demonstrates across census group categories that decisions on breastfeeding correlate with inequalities in education and socioeconomic status, as breastfeeding is less common among those with less education and income (Hirschman and Butler 1981; Ryan et al. 2002). For this reason, it has been argued that low breastfeeding rates among Blacks reflect a racial disparity in economic resources (Lee et al. 2009), including access to formal education.

While this may be true in part, SES is actually insufficient for determining whether or not a mother will decide to breastfeed. Research studies have continually supported the opinion that SES is a primary factor in creating disparities in breastfeeding behavior and that women with higher SES are more likely to breastfeed than women with lower SES (Johnson, Kirk, Rosenblum, & Muzik 2015; Lewallen & Street 2010; McDowell, Wang, & Kennedy-Stephenson 2008). However, the influence of SES has been found to be inconsistent. Low SES fails in explanation of the higher initiation rates among low income foreign-born Black women.
Researchers have noted that foreign-born Black women were more likely to breastfeed their infants compared with native-born Black women (Lee et al. 2009; McCarter-Spaulding & Dennis 2010; McCarter-Spaulding & Gore 2009; Ogbuanu et al., 2009; Sparks 2011). Breastfeeding rates for foreign-born Blacks, however, tend to coincide with the rates of native-born Blacks within a decade (DeVane-Johnson et al. 2017), a finding which also supports the notion that culture influences health more significantly than race (Dodson 2012).

SES may be an unreliable argument when comparing lower income native-born Americans. While Black households in 2011 had a substantially lower median household income ($32,229) than non-Hispanic Whites ($52,214) and Asians ($65,129), the median income for Hispanic and American Indian households were closer to that of Blacks ($38,624 and $35,062, respectively). Yet, significantly more Hispanic and American Indian infants were breastfed (82% and 77%, respectively) than Black infants (62%). Among enrollees of the Special Supplemental Food Program for Women, Infant and Children (WIC), a program designed to prevent malnutrition and reduce infant mortality, rates are found to differ even though economic resources are fairly constant among enrollees. One study of breastfeeding rates at hospital discharge (Ryan et al. 1991) found overall rates for WIC enrollees (34%) – already lower than the national average for all new mothers (52%) – were still higher than rates for Black mothers (23%). In addition, Black mothers enrolled in WIC were the least likely of all enrollees to initiate breastfeeding (Baydar et al. 1997).

The intersection of race, culture and SES is important to note because the arguments that identify SES tend to invalidate race and culture, as though to say that in the absence of economic disparities between groups, the effects of racism and health disparities would disappear. Baker (1998) outlines a political and social history of the construction of racial categories in the US,
which includes a fairly contemporary argument against the existence of race. While anthropologists have argued for decades against the notion that a genetic foundation for race exists, they have argued in support of race as a social and political construct with very real effects on people of color. Examples of this appear in studies of various cultural groups of Black residing within the US (DeVane-Johnson et al. 2017) or from different SES backgrounds (Spencer and Grassley 2013), which demonstrate differences in health outcomes even when the variables in question are controlled. This confirms an effect of race that is worthy is distinct consideration in the absence of other cultural and social differences (Kawachi, Daniels and Robinson 2005; McCall 2005), such as among middle/upper class Blacks.

While economic disparities have been shown to reduce a population’s access to certain resources, the disparities in breastfeeding rates between middle/upper class Black mothers and middle/upper class mothers of other census group categories are more difficult to explain. The lack of available research on breastfeeding practices of middle and upper class Blacks leaves a hole in the research that is vital to understanding lower breastfeeding rates in Black communities.

The research proposed herein is designed in part to focus on a need addressed by Kathi Barber, author and breastfeeding advocate, in an article on lactation in the African American community:

“…most lactation research studies focus on Black mothers from the WIC or low-income populations… [there] is a miniscule number of research and recorded data that takes into account the nuances of Black women from Middle America… how do the breastfeeding rates, practices and beliefs of middle and upper class Black
women factor into the true picture of Breastfeeding in the African American community?” (Barber 2014 p. 100)

There is evidence which suggests that Black mothers of all education levels in the state of Florida are less likely to breastfeed than mothers of other census categories (Florida Dept. of Health, Bureau of Vital Statistics 2014; see table 2.3). Across groups, mothers with less than a high school diploma are the least likely to initiate breastfeeding. Education is a clear differentiator, as all census categories of mothers with high school diplomas, some college, and bachelor’s or graduate degrees are more likely to initiate breastfeeding than those without a high school diploma. However, even among mothers with at least a bachelor’s degree, Black mothers are the least likely to initiate breastfeeding. The differences are smaller among highly educated mothers, but they are present nonetheless.

**TABLE 2.3: 2013 FLORIDA BIRTH RATES OF MOTHER’S EDUCATION AND BREASTFEEDING INITIATION BY RACE/ETHNICITY**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Less than High School diploma</th>
<th>High School diploma/ GED</th>
<th>Some college or 2yr Degree</th>
<th>Bachelor, Master or Doctoral Degree</th>
<th>Total births*</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5194 (61%) 3275 (39%) 8469 (100%)</td>
<td>19288 (77%) 5667 (23%) 24955 (100%)</td>
<td>25732 (86%) 4088 (14%) 29820 (100%)</td>
<td>29303 (94%) 1896 (6%) 31199 (100%)</td>
<td>94443</td>
</tr>
<tr>
<td>Black</td>
<td>4967 (60%) 3362 (40%) 8329 (100%)</td>
<td>12737 (68%) 5899 (32%) 18636 (100%)</td>
<td>11342 (80%) 2790 (20%) 14132 (100%)</td>
<td>5233 (91%) 503 (9%) 5736 (100%)</td>
<td>46833</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10413 (82%) 2225 (18%) 12638 (100%)</td>
<td>16404 (86%) 2571 (14%) 18975 (100%)</td>
<td>14124 (92%) 1272 (8%) 15396 (100%)</td>
<td>10368 (100%) 583 (5%) 10951 (100%)</td>
<td>57960</td>
</tr>
<tr>
<td>Other</td>
<td>652 (71%) 264 (29%) 916 (100%)</td>
<td>1968 (83%) 402 (17%) 2370 (100%)</td>
<td>2597 (89%) 305 (11%) 2902 (100%)</td>
<td>4346 (100%) 212 (5%) 4558 (100%)</td>
<td>10746</td>
</tr>
<tr>
<td>Total*</td>
<td>21226 (70%) 9126 (30%) 30352 (100%)</td>
<td>50397 (78%) 14539 (22%) 64936 (100%)</td>
<td>53795 (86%) 8455 (14%) 62250 (100%)</td>
<td>49250 (94%) 3194 (6%) 52444 (100%)</td>
<td>209982</td>
</tr>
</tbody>
</table>


The data presented in table 2.3 calls into question the differences that influence breastfeeding initiation between educated Blacks and other census group categories of educated
women. Based on the premise that education and income increase the likelihood of breastfeeding, disparities in breastfeeding rates should then disappear between mothers with similar years of education. The fact that disparities still exist between breastfeeding rates for Black mothers and other census categories with similar education (91% vs. 94-95%) indicates that additional unnamed factors may contribute to lower breastfeeding rates of Black mothers.

The same phenomenon is evident among Florida births in an examination of delivery payment source by race (table 2.4). “Medicaid” category, comprised of individuals in the federal aid program that offers free or low-cost care for low-income people, includes those who are “low income.” “Private insurance” and “self-pay” are categories more likely to include those who are either “middle income” or “upper income.” In table 3, infants born to mothers on Medicaid (low-income) are less likely to have been breastfed than infants born to mothers with private insurance or those who self-pay (middle/upper income).

However, Black mothers remain the group least likely to initiate breastfeeding regardless of delivery payment source. While disparities between initiation rates for Medicaid-enrolled mothers and either private insurance or self-pay mothers are expected due to resource variations between low and middle/upper income mothers, what is unclear is why the variation exists across census group categories within the same pay categories. Similar to the data in table 2.3, table 2.4 suggests that some additional factors influence Black mothers to initiate breastfeeding less often than other census categories of mothers of similar income.
TABLE 2.4: 2013 FLORIDA BIRTH RATES OF DELIVERY PAYMENT SOURCE AND BREASTFEEDING INITIATION BY RACE

<table>
<thead>
<tr>
<th>Race</th>
<th>Medicaid</th>
<th>Private Insurance</th>
<th>Self-Pay</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfeeding Initiated?</td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>30376</td>
<td>10500</td>
<td>40876</td>
<td>50308</td>
</tr>
<tr>
<td></td>
<td>79%</td>
<td>21%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>22753</td>
<td>10702</td>
<td>33455</td>
<td>10467</td>
</tr>
<tr>
<td></td>
<td>68%</td>
<td>32%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>27290</td>
<td>4593</td>
<td>3883</td>
<td>17204</td>
</tr>
<tr>
<td></td>
<td>82%</td>
<td>18%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Other</td>
<td>3326</td>
<td>728</td>
<td>4054</td>
<td>5647</td>
</tr>
<tr>
<td></td>
<td>82%</td>
<td>18%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>83745</td>
<td>26523</td>
<td>11026</td>
<td>1342</td>
</tr>
<tr>
<td></td>
<td>76%</td>
<td>24%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Totals above reflect identified data. All "unknown" values are excluded from this table.

EMPLOYMENT

One key factor that is argued to influence breastfeeding rates is mother’s employment during and after the birth of a child. Black mothers are more likely to have lower paying service-sector jobs than mothers from other ethnic groups (Ringer-Kulka et al. 2011; Smith-Gagen et al. 2014). Black mothers tend to have shorter maternity leaves as well when compared with women of other ethnic groups (Johnson et al. 2015; Spencer & Grassley 2013). The need to return to work has been shown repeatedly to be the most common reason for women to not breastfeed an infant (Fischer & Olson 2014; Hannon et al. 2000; Hill, Arnett, & Mauk 2008; McCarter-Spaulding 2007; Ogbuanu et al. 2009).
Anthropologists speculate that working outside of the home causes mothers to be away from their infants for long periods, leading to less frequent breastfeeding and reduced milk production (Quandt 1985). Interestingly, Van Esterik and Greiner argue that work as a reason for decreased breastfeeding is over exaggerated and mothers who work close to home and have breaks are able to breastfeed or pump during the day (1981). However, in instances where mothers need additional support, the authors offer suggestions to support mothers including sharing infant care duties with fathers, who are described as an often an untapped resource.

Mothers who do manage to work during the day and breastfeed infants when they come home hold two worlds in perfect balance. It is not uncommon for a mother to pump breast milk during the day at work and to nurse her baby through the night (Tomori et al. 2016). Wright et al. (1993) found, for many women, work away from home tends to be affiliated with making complex arrangements for housework, child care, and transportation, as well as juggling multiple demands from employers, husbands, and older children. These complexities result in time constraints that make delegating feeding chores to someone else more attractive. Thus, there may be an inherent conflict perceived between being able to breastfeed an infant while meeting the responsibilities in the job.

**Historical and Social Constructions**

Among feminist explorations of breastfeeding (Blum 1993; Blum 1999; Carter 1995; Gorham & Andrews 1990; Hausman 2003; Murphy 1999; Stearns 1999), Blum (1999), Carter (1995) and Hausman (2003) frame women’s experiences with historical and social constructions. Wall (2001) also suggests that social considerations of nature and what is natural impact the discourse of breastfeeding. She argues that the notion of the natural woman, contextualized in the nature/culture dichotomy, is bound to the understanding that some women, namely women of
color and working-class women, are closer to nature and more in touch with their natural functions than others (Blum 1999; Carter 1995; Maher 1992).

Embedded in US history are negative images of Blacks as savages, and modern Black mothers are likely to embody, on some level, fears of being considered as savages for engaging in such naturalistic behavior as breastfeeding (Blum 1999; Power 1999; Golden 1996). Golden (1996) describes perceptions of breastfeeding from the nineteenth century that ring true today when she says "well-to-do women saw breastfeeding by lower class women as animal-like" (p. 205). The history of exploitation of Black mothers as handmaids, wet nurses and childcare providers during slavery needs to be considered for its contributions to minimizing exclusive motherhood (Blum 1999) and, thereby, minimizing the necessity for breastfeeding.

Carter’s work (1995) in particular, focused on mothers in the United Kingdom, encourages readers to consider mothers’ varied experiences of infant feeding and the notion of “the natural.” She posits that policies on breastfeeding can function as instruments of control that grant authority to various institutions in order to police the bodies of low income, less educated Black mothers, a group whose practices and definitions of good motherhood have long been suspicious to middle class Whites. These mothers often struggle to reconcile their decisions for how to feed their infants between how they define appropriate behavior in both public and private spaces and heteronormative expectations of the sexual function of women’s breasts which can differ for Black and White women. There is a particular struggle in aligning with the concept of “nature” and “natural behavior” presented in breastfeeding discourse because these same terms are used derogatorily to describe racial minorities as primitive and unevolved. Based on the perspectives above, one could build an argument that the feminist “choice” for civilized Black mothers would be to rebuke breastfeeding and instead make the feeding choice – formula
feeding – that has advanced in recent times thanks to the advancements of civilization and modernity.

**RACISM**

These arguments raise issues of racial stereotyping, and also perpetuate the notion that all women can breastfeed successfully or that they should (Blum 1999). Such notions can be dangerous when they contribute to the roles of racial stereotypes and racism in breastfeeding. Breastfeeding research does not tend to implicate racism for low breastfeeding rates, though one study did find that “race-associated differences in health outcomes are in fact due to the effects of racism” (Dodgson 2012).

Jones (2000) developed a theoretical framework for understanding multiple levels of racism and their roles in contributing to poor health outcomes for ethnic group populations. She defines race not as a biological construct but as a “social construct that precisely captures the impact of racism” (p. 1212) and goes on to say that some scientists hypothesize that race-associated differences in health outcomes are due to the effects of racism. Institutionalized racism, defined as differential access to goods and services, is described as normative, an inherent disadvantage and inaction in the face of need. Personally mediated racism was defined as prejudice and discrimination, or assumptions about the motives and abilities of others according to their race. Internalized racism is defined as acceptance of negative messages from other ethnic groups about the abilities of one’s own ethnic group, and manifests as accepting “whiteness,” devaluing the self and hopelessness and risky behavior.

Dodgson (2012) applies this framework to historical and contemporary examples of breastfeeding disparities. Institutionalized racism, she explains, occurs so frequently that it is invisible to medical staff. Participants of one study denied the existence of race-based
discrimination in medical treatment in which predominately White staff from a second study reportedly deprioritized women of color’s medical needs because they assumed their needs would take more time. In a study of breastfeeding advice given by medical staff and WIC counselors, Black and White women reported receiving the same advice from medical providers while Black women were more likely to report receiving bottle feeding advice from WIC counselors (Beal, Kuhlthau & Perrin 2003).

Feminists and critical race theorists (Beal et al. 2003) have asserted that empirical research approaches rooted in “nineteenth century White European cultural biases and privilege” (Beal et al. 2003, p. 77) create a level of structural bias that reduces the ability to clearly see the effects of culture within racial groups. One example is collapsing ethnic groups into racial categories that lack sufficient detailed, historical distinction. Thus, when scientists present breastfeeding disparities as “Black” or “African American,” they are unable to report that foreign-born Blacks have much higher breastfeeding rates. The more nuanced elements of native-born Blacks’ experiences become minimized and are not easily addressed given that the true rates are not actually reported.

These examples of racism can minimize meaningful cross-cultural understandings. When racism and structural bias occur, Black mothers can be affected despite education level or economic status (Johnson et al. 2015). Further, the concept of habitus offers a framework within which it is possible to understand how social constructions of bias can become embodied as lived experiences that imprint onto African American women’s memories. It may be possible that the impact could be for Black women to discount future teachings of health providers as valueless and irrelevant long term, despite how beneficial or appropriate breastfeeding might be for their personal goals and family’s needs.
WHAT’S MISSING FROM CURRENT APPROACHES

APPROPRIATENESS OF DETERMINING BREASTFEEDING AS “THE GOLD STANDARD”

In All Our Kin, Stack (1975) suggests that Black mothers utilize a strategy of kinship that enables them to survive through extreme poverty and conditions in a way that is normative to Blacks but not Whites. This is one example of how using what is appropriate for one population could be inappropriate if applied to all other ethnic groups. The opposite appears true when it comes to determining a standard for breastfeeding behavior.

While the benefits of breastfeeding have been studied for the impacts on both the health of the mother and baby, some have argued that breast milk is not the ideal food it is claimed to be. In Joan Wolf’s book Is Breast Best? (2011), the reader is called to consider the quality of data available in studies that compare the benefits of breastfeeding over using infant formula. She claims that infant feeding research is unreliable because it is based upon observational data, being unable to randomly assign infants to either be breastfed or formula fed and therefore relying upon what is available.

Also interesting to note is Wolf’s argument (2011) that low-income, less educated mothers who breastfeed are more likely to have the resources to behave and commit as higher educated, higher income mothers would. This suggests that the outcome of breastfeeding may not be attributable directly to breastfeeding but may, in fact, be attributable to healthy habits that are independent of breastfeeding. Wolf asserts, similarly to Blum (1999) and Carter (1995), that there is an interaction between control of women’s bodies and medicalization of infant feeding.

Morrissey and Kimball (2017) call for a re-consideration of who breastfeeding benefits, and who suffers the consequences of not breastfeeding. They assert that Black mothers seem to be in a position that is impossible to reconcile (Morrissey and Kimball 2017). Cultural narratives
of African Americans depict Black women as overly dependent upon public assistance, an image that challenges them to work as a demonstration of independence, while working Black mothers become framed as inadequate mothers for being overly committed to their work (Triece 2012). Morrissey and Kimball (2017) describe mothers as needing to hold jobs outside of the home in response to the effects of institutional racism which has made achieving financial independence difficult for Black families. This is especially true for Black mothers who are single parents, which is the highest for Black families compared with all other ethnic groups in the US (Martin et al. 2012). Single parents are not in a position to consider the luxuries that are afforded to middle class mothers who do not have to work.

However, working causes Black mothers to be criticized for being independent, a claim which indicates that not being home creates a noticeable absence to their families. As stated by Triece (2012), paraphrasing Fraser (1989): “The competing demands of capital and care placed poor Black women in a double bind—if they chose to stay home to care for their children, they were labeled lazy or ‘welfare queens;’ if they assumed jobs in the labor force they were labeled ‘failed mothers’” (Triece 2012, p. 2). Reid-Brinkley (2011) states that “the Good White Mother in the U.S. social imagination stands as an idealized standard for femininity that constrains all women across various intersections” (Reid-Brinkley 2011, p. 46). Morrissey and Kimball (2017) explain that Black women, in contrast, are viewed as “inadequate and/or bad mothers whose ambition, independence, and sexuality are suspect” (Morrissey and Kimball 2017, p. 51). And yet the expectation to breastfeed adds another layer on top of this already this impossible standard that seems to sit with Black women alone. Not having this insight into Black women’s unique positionality and the cultural expectations placed on them to be “good women” or “good
mothers” could make it possible to miss the inappropriateness of placing normative breastfeeding behavior for White women onto any other ethnic group.

THE INFLUENCE OF BLACK COMMUNITIES

Bentley et al. (1999) found Black mothers face challenges that are unique to their communities, most notably the expectations of their partners, female relatives, friends and providers, as well as previous exposure to and experiences of breastfeeding. A mother’s relationships with others can exert an influence on how she decides to feed her infant. Spencer and Grassley (2013) and Wiemann et al. (1998) have argued that a Black mother is likely to breastfeed if she has a close relative or family friend who also breastfed a baby. Likewise, having spousal support is a significant predictor of both initiating breastfeeding and continuing to breastfeed once initiated (Bentley et al. 2003; Giugliani et al. 1994; Hill et al. 2008). Negative and unsupportive comments tend to have the opposite effect. A mother who feels unsupported can be persuaded not to breastfeed, even if doing so was her original intention (Lewallen & Street 2010; Meyerink & Marquis 2002; Spencer et al., 2015; Street & Lewellan 2013).

Extensive breastfeeding education focused on Black mothers has been found to be insufficient to sustain real change, as most mothers discontinued breastfeeding by ten days postpartum (Gross et al. 1998; Caulfield et al. 1998). Spencer and Grassley (2013) argue that sustainable change requires developing a culturally-sensitive education model that includes seeking community support and identifying role models, concepts that are largely unacknowledged in the literature.

A few support campaigns across the country claim to be successful in increasing breastfeeding among Black mothers and are initiatives started and supported by Black mothers (BMBFA 2018, AABN 2018, BB360 2018). These efforts are part of a progressive movement
among social media which acknowledges that Black women do, in fact, breastfeed. Organizations such as Black Mothers’ Breastfeeding Association (BMBFA 2018), African American Breastfeeding Network (AABN 2018), Black Breastfeeding 360 (BB360 2018), and websites such as Black Women Do Breastfeed (www.blackwomendobreastfeed.org) and Mocha Manual (http://mochamanual.com) celebrate breastfeeding and other successes of Black mothers and families. They employ the types of efforts for which Spencer and Grassley (2013) argue, providing support and education in the forms of support groups, seminars and written materials developed by and targeted to Black communities and demonstrating increased partner, family and community support to breastfeeding mothers (BMBFA 2018; AABN 2018; BB360 2018; Allers 2006).

The majority of breastfeeding interventions addressed to Black mothers are designed to reach low income, less educated mothers rather than focusing on the specific needs of Black communities (Spencer & Grassley 2013). Arguments tend to be made for the needs of economically disadvantaged populations, who are described as being less educated about the benefits of food and its effects on health in general (Coveney 2005). To increase lay knowledge of breastfeeding benefits and techniques, a number of local and statewide support and advocacy agencies provide education free of charge (for local examples, see Tampa Bay Breastfeeding Taskforce 2018).

However, mothers are likely to encounter some information from prenatal care providers or other sources regarding breastfeeding benefits, since the literature shows that many know that breast milk is the ideal infant nutrition (Lupton 2000). Blum (1999) notes that women she studied were familiar with the concept “breast is best” and did not seem to have a “knowledge lag” (Blum 1999, p. 120), in spite of low breastfeeding rates and a short duration. Thus, the
solution to racial disparities in breastfeeding may require more than educating Black communities on the benefits of breastfeeding.

**INFANT FEEDING CULTURE IN THE US**

In addition to being ideal infant nutrition, anthropologists have long since recognized that breastfeeding is an intimate social interaction between mother and baby (Fouts, Hewlitt & Lamb 2012). There is little evidence, however, to indicate whether the closeness afforded by the breastfeeding relationship is of value to Black mothers. This is not to suggest that Black mothers are a subgroup without the same values as other groups, but rather that this issue has not been well studied or documented.

What is common to see in the literature is that Black mothers indicate "breast milk alone did not satisfy my baby" as a reason to discontinue breastfeeding (Li et al. 2008). Misconceptions of infant satiety can lead mothers to switch babies from breast milk to infant formula in an attempt to do what they think is best for baby (Amir 2011). It is unknown, however, whether being better educated either about normal feeding cues for determining infant satiety or the benefits imparted to infants through the act and intimacy of breastfeeding would be valuable enough knowledge for mothers to continue to breastfeed.

It has been speculated that cultural differences—specifically, being born and raised in a culture where feeding mother’s milk is normalized—might be an important variable for understanding infant-feeding decisions (DeVane-Johnson 2017). However, these data could suggest that cultural influences and how women are socialized about human milk feeding may be an important variable for understanding infant-feeding decisions.

Breastfeeding has been tricky to establish in the United States, where mothers are often told “they are violating public morality when they breastfeed in public” (Van Esterik 2002, p.
Unlike African, Asian, Latin and European countries where public breastfeeding is more common, American women negotiate the act of breastfeeding in front of others with the use of cover ups and slings, tools that allow for public feeding while maintaining discretion (Stearns 1999).

Stearns (1999) describes breastfeeding as a performance in which mothers are vigilant about knowing safe, less obvious locations where they can breastfeed while minimizing either offending or arousing onlookers. Coupled with these efforts is the fact that the right to breastfeed in public or in private free from harassment or threats is now supported by law (National Conference of State Legislatures 2017). But while breastfeeding laws protect a mother’s right to breastfeed in 49 states, only 29 of those 49 states exempt breastfeeding women from public indecency laws (NCSL 2017). Inconsistent support at the legislative level is a valid reason why many mothers hesitate to breastfeed in public spaces. A breastfeeding mother who is out with her infant could find herself either feeding her baby in unsanitary but hidden spaces such as a public restroom, or taking a risk to feed her baby in public. It is not surprising that mothers may find neither option holds appeal.

**Morality**

Lee et al. (2010) suggested that arguments against the use of formula are rooted in moral judgment and are based upon the risks of not receiving breast milk. Parents who use infant formula then become identified as “(inadequate) risk managers” (Lee et al. 2010). This concept of risk is consistent with the ‘breast is best’ message and is grounded in arguments that infant formula is more of a ‘risk’ for infants than breast milk. Promoting breast milk as being superior to infant formula also informs a discourse of morality around infant feeding in which “good mothers” breastfeed their infants (Lee 2011) and bad mothers use formula.
Researchers have asserted that public discourse on breastfeeding is deeply interconnected with the morality of mothering (Knaak 2010, Lee 2007, Lee 2008). It may be that messages from public health campaigns on breastfeeding have contributed to a type of breastfeeding hegemony that preys on fear and uses risk to promote its agenda (Knaak 2010). This message promotes the ideology of “unlimited self-sacrifice, and ultimately adds a considerable burden of guilt, stress and regret to decisions about feeding infants” (Ludlow et al. 2012, p. 292).

Ludlow (2012) explains that social scientists have struggled with the issue of breastfeeding, with how or whether breastfeeding behavior should even be promoted. Wolf (2017) claims that it has gone as far as attempting to deny evidence on the benefits of breastfeeding for women and their children. Ludlow (2012) further explains that breastfeeding researchers need to walk a fine line between promoting breast feeding and honoring a mother’s infant feeding decisions. The challenge for mothers is to determine whether the so-called risk of using infant formula is worth the benefits it affords. In addition, mothers may be faced with definitions of motherhood based upon infant feeding choices that either support or contradict the mother’s own beliefs.

There is growing concern over breastfeeding promotion messages that equate “good motherhood” with individual mothers' decisions to breastfeed without considering the structural and sociocultural barriers to breastfeeding (Hausman 2003; Lee 2007; Lee 2008; Murphy 1999; Tomori 2014; Wolf 2007; Wolf 2011). When a mother’s own values and life circumstances happen to coincide with breastfeeding, as is more common for middle class White mothers, then the notion of breastfeeding as “good motherhood” becomes a supportive and helpful notion (Blum 1993, Carter 1995, Wolf 2011). However, when those values and circumstances contradict breastfeeding, as is more common among Black mothers, then the message of
breastfeeding as good mothering may become antagonistic and serve to marginalize those who either lack resources and support or who simply do not choose to breastfeed. The effect may have resulted in Black mothers, some of whom do breastfeed but at lower rates than mothers from other ethnic groups, being stigmatized as bad mothers (see section “ Appropriateness of determining breastfeeding is ‘the gold standard’” above) and left to create an alternative definition of good motherhood that is poorly understood by the mainstream population.

**CONCLUSION: WHY THIS DISSERTATION RESEARCH IS NECESSARY**

The disparity that exists between breastfeeding rates for Black and non-Black mothers has existed for decades. More infants are reportedly breastfed every year across US ethnic groups and Black infants are no exception (CDC 2014). There are widespread efforts underway targeted to increase rates among Blacks in particular, given that they breastfeed less often and less consistently than other groups. But the most recent statistics show that 68% of Black infants were ever breastfed in 2014, up from 60.7% in 2009 (CDC 2014). These rates lag 10% points behind the next closest ethnic group. However, the rates still represent the majority of Black infants, signifying that Black mothers do, in fact, breastfeed.

The literature reviewed above outlines the contributions of scientists to our knowledge base about the disparity between Black and non-Black breastfeeding rates. The question that remains unanswered, according to numerous studies on the subject, is why there is any disparity at all. Studies to understand the differences in breastfeeding rates most often focus on what is missing or deficient in Black populations that appears available to other ethnic groups. Is it knowledge about breastfeeding behavior that Blacks lack and others seem to have inherently? Is it awareness of the benefits of breastfeeding for mother and baby that Black mothers do not seem to know that every other ethnic group does know? The nature of these very questions contain
assumptions that could be considered discriminatory. If one assumes deficiency on the part of Blacks, then the current strategies to educate them may appear obvious. But the belief that Blacks seem to be missing what all other groups have should also signify an inherent inability to benefit even from education.

However, because anthropologists and other scientists have suggested that there may be social determinants--both historical and contemporary--that contribute to why Black infants are less likely to be breastfed, we have some sense of what needs to be examined in greater detail. Anthropologists and other researchers have argued that the lived experiences of Black mothers, their shared histories, and the beliefs and values they embody contribute to the habitus that governs the decision not to breastfeed, thus explaining why the disparity exists.

My research builds upon this knowledge by examining whether this notion of embodied values, beliefs and experiences determining how Black mothers feed their infants applies in Tampa Bay. It directly asks the mothers how they define good motherhood, asks what is most valued by Black mothers of newborn infants and also asks for their experiences of early motherhood in order to provide a three-dimensional picture of mothers who breastfed to compare to those who did not. It also removes low socioeconomic status and the effects of SES from the equation by focusing strictly on middle class Black mothers, an understudied population, to determine whether the findings of these issues among low income, low educated Black mothers are an economic phenomenon or a cultural one. Examining this from the perspective of MCAMs ultimately enables some clarity of whether health education initiatives alone have the ability to produce lasting change or whether additional efforts beyond increasing breastfeeding knowledge of mothers would be more successful both at increasing rates and supporting mothers’ needs.
CHAPTER THREE: METHODOLOGY

Chapter Three presents the methodology for the study beginning with an understanding of the four primary research questions (RQs) that guide this dissertation, objectives and hypotheses for each question. It then outlines the three phases of research and details the data collection methodologies, inclusion criteria, observation sites, and the development of the research assessment tool. Finally, I provide an overview of how the data was analyzed.

RESEARCH QUESTIONS

The research questions are:

RQ1: How do Middle Class African American Mothers (MCAM) define being a “good mother” and how does breastfeeding in particular compare with those values during early infancy?

Objective 1: The first objective was to identify how MCAMs define being a “good mother,” to learn what they value during their baby’s early infancy, and to determine how breastfeeding is prioritized in comparison with formula feeding and other values they hold.

Hypothesis 1: African American mothers define “good motherhood” as providing the best they can for their children, which may or may not include breastfeeding their infants. They may regard breastfeeding and the benefits attributed to breast milk as less valuable in comparison with other values they hold, such as their work income and the ability to provide for their families, the opinions of those close to them (such as the baby’s father, close relatives and friends), their baby’s perceived satiety and health, the ability to share feeding and child care with
others, which they believe is easier to do with formula than by breastfeeding, and fulfilling their definition of being a “good mother”.

**RQ2: What factors do MCAM perceive as discouraging them from breastfeeding?**

Objective 2: The second objective is to identify factors that MCAM perceive discourage them from initiating or continuing to breastfeed.

Hypothesis 2: African American mothers believe that breastfeeding competes with work and other activities. They perceive breastfeeding among close relatives and peers as being a low priority within their communities and fear judgment. Additionally, there is a lack of role models and the skillset for breastfeeding within their communities that discourages breastfeeding as a priority for new mothers.

**RQ3: What influences a MCAM’s decision to breastfeeding or bottle feed her infant?**

Objective 3: The third objective is to understand what influences MCAMs to either breastfeed or bottle feed their infants, or to change from one feeding option to another.

Hypothesis 3: African American mothers’ decisions to breastfeed are influenced by whether they value the physical benefits of breastfeeding, by concerns about how satisfied they perceive their babies to be after feeding, and by support or lack of support from spouses, relatives, employers and others close to and influential in the mother’s life. They also are influenced by whether or not they believe that breastfeeding can be done without devaluing something else they value.

**RQ4: What models or strategies have been successful in supporting and encouraging MCAMs to breastfeed? What is unique about these models in comparison with those that are unsuccessful?**
Objective 4: The fourth objective is to identify models or practices that have resulted in MCAMs’ successfully breastfeeding their infants.

Hypothesis 4: Successful models offer education and support to all African American mothers, partners and extended family rather than targeting low income mothers alone. Education and support initiatives make breastfeeding attractive to African American families by being lead by African American mothers who breastfeed, by including culturally sensitive images of African American families in educational materials and also addressing issues of concern for their communities. Finally, they also create a flexible strategy for infant feeding that meets African American mothers’ definitions of “good motherhood.”

**Research Strategy**

Based upon the gaps identified in the scientific literature on the issues listed above, it was determined that qualitative methodologies would be best to ascertain the values, influences and perceptions that result in low breastfeeding rates among MCAMs and to learn what practices have successfully increased breastfeeding. Although I began preliminary observations several years prior to the start of this research study, this research began in January 2017 with the approval from University of South Florida to formally conduct Human Subjects’ Research. Data was collected in **three phases** through October 2017.

- Phase I was an informal ethnography based upon participant observation of Black and African American mothers throughout Tampa Bay. This phase began in January 2017 and focused on community-based observations of feeding and interactions between mothers and infants in various locations throughout Tampa Bay. Direct observations allowed for minimal disruption in the usual interactions of mothers and infants, and for
informal conversation with study population prior to formal study using interview questions. Participant observation was an essential component to contextualizing breastfeeding within a normative model of infant feeding practices among African American mothers. Observing normal infant feeding practices of this population also helped to inform the following study phases.

- Phase II was an exploratory study that utilized semi-structured interviews with key informants to address research questions 1, 2, 3 and 4. Beginning in April 2017, key informant participants were identified as professionals with a unique perspective as birthing and infant care experts who work with African American mothers. Findings from interviews detailed expert opinions of the infant feeding values (H1), beliefs/perceptions (H2) and influences (H3) of African American mothers and also uncovered successful strategies for supporting African American mothers (H4). Findings from interviews with subject matter experts also helped to finalize the interview tool used for interviews with African American mothers during the next phase.

- Phase III was an exploratory study that utilized semi-structured interviews with African American mothers to address research questions 1, 2, 3 and 4 by assessing how MCAM value breastfeeding (H1), identifying perceived obstacles to breastfeeding (H2), determining what influences the decision on how to feed their babies (H3), and determining the needs of African American mothers who breastfeed (H4). The third research phase began in May 2017.

**STUDY SITE – HILLSBOROUGH COUNTY, FLORIDA, USA**

Hillsborough County is located on the central west coast of the state of Florida. Breastfeeding initiation rates for all census group categories in 2013 were higher in this county
compared with rates for the state of Florida (see table 3-1). 89% of non-Hispanic White mothers initiated breastfeeding with infants, as did 90% of Hispanic mothers and 93% of mothers of other census group categories. The mothers in Hillsborough County who were least likely to initiate breastfeeding were Black (79%). This rate is higher when compared to breastfeeding initiation by Black mothers in the state (73%) and nationally in 2011 (62%, see table 3-1). Despite higher rates for Black mothers in Hillsborough County, however, a significant disparity still exists between initiation rates for Black mothers and all other groups. Because Black mothers have higher breastfeeding initiation rates than either the state or national average and still have rates lower than White women, Hillsborough County is the ideal site for examining this phenomenon.

**Table 3.1: 2013 Rates of Breastfeeding Initiation for Births by Race of Infant by County and State**

<table>
<thead>
<tr>
<th>Race</th>
<th>Hillsborough County, FL</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfeeding Initiated?</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>6,537</td>
<td>808</td>
</tr>
<tr>
<td>Column %</td>
<td>89%</td>
<td>11%</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>2,754</td>
<td>715</td>
</tr>
<tr>
<td>Column %</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4,365</td>
<td>498</td>
</tr>
<tr>
<td>Column %</td>
<td>90%</td>
<td>10%</td>
</tr>
<tr>
<td>Other races/ethnicities</td>
<td>837</td>
<td>60</td>
</tr>
<tr>
<td>Column %</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>Total Births</td>
<td>14,493</td>
<td>2,081</td>
</tr>
<tr>
<td></td>
<td>87%</td>
<td>13%</td>
</tr>
</tbody>
</table>

*Totals above reflect identified data. All “unknown” values are excluded from this table.

**DATA COLLECTION – PHASE I – PARTICIPANT OBSERVATION**

Ethnography is a valuable tool for understanding the health behaviors of a population. Infant feeding is a health behavior that requires direct observation in order to appropriately
situate and contextualize African American mothers within an appropriate narrative framework. Unlike the public health studies that have focused on low income populations to explain poor rates of breastfeeding among Black and African American families, this study instead focused on middle class African American mothers (MCAMs). This purposeful attention to MCAMs enabled the observation of an underexplored and underrepresented minority within this ethnic group with the purpose of learning whether the factors that are believed to contribute to low breastfeeding rates among African Americans are racially and ethnically entrenched, or whether the factors are related to class constructions. This insight is essential to understanding how to best assert useful explanations of the experiences of African American mothers that can be used to develop strategies to increase breastfeeding rates in Tampa Bay.

Participant observation techniques were used to observe feeding and various interactions between African American mothers and infants in community settings throughout Tampa Bay. Using phenotype was potentially an ineffective way to identify the subjects for this phase of study, but unfortunately it was the only option. Given the diversity of humans who have similar skin color, eye color, hair color and hairstyles, as well as similarities in the style of clothing they wear, languages they speak and a number of other aspects of being members of society in the United States, use of physical characteristics can be a grossly inaccurate way to identify members of a cultural or ethnic group (Mukhopadhyay and Henze 2003). Among those with similar skin color living in the United States, many ethnic groups are represented within the large racial group categories used by the US census bureau despite not sharing the same histories, cultures or social experiences. As an observational study, there was no accurate method for determining with any certainty which mothers identify as being Black or African American. By
using this technique, I risked observing mothers who fell into the larger racial category “Black” but who may not have identified culturally as being “African American.”

Nevertheless, I used phenotype to identify the population that was the target of my observations. In order to maintain independence and anonymity as a researcher and to observe mothers without disturbing their natural interactions, I identified mothers as African American based upon physical characteristics such as skin color, hair texture, hair color, hairstyle, and facial features (Fuchs et al. 2002). Mothers who I identified as African American usually had brown skin color, dark hair color and either tightly curled, kinky, chemically relaxed, weaved, braided or dreadlocked hair. This method enabled me to observe the phenotype of Black mothers and their infant feeding behaviors in comparison with the behaviors and experiences of mothers who did not have the same characteristics. I did not observe phenotype of infants or children, as the focal point of this research was the experiences and choices of mothers.

Bernard (2011) describes the role of participant observer as one that combines being a complete participant and a complete observer. For meetings that I attended, rather than becoming a member of the group without alerting my subjects that I was doing research or being an observer who kept those lines clearly delineated, I was able to participate both as a member and as an outsider. The primary method utilized to denote these observations was field notes, which was the main data source for constructing a picture of MCAMs in Tampa. In each of these settings, carefully detailed field notes were written either during the event or immediately following which outlined the date, location, and a number of observations in each setting. The notes captured:
• A physical mapping and description of each setting, including a description of spaces where mothers and infants frequented, others who were present in the space, and related details about the physical environment.
• The presence of mothers and infants under the age of five years old from different races and ethnicities.
• The presence of Black or African American mothers, determined based upon phenotype.
• How Black or African American mothers interacted with their children, particularly with regard to how children were fed or otherwise cared for.
• Conversations had, either separately or as a whole (in the cases of meetings and groups).
• Behaviors that seemed to connote discomfort or other reactions of mothers and others.

Black mothers and infants’ activities, including feeding techniques in public settings, were noted. When possible, I also engaged mothers in informal conversations about infant feeding to obtain some insight into why mothers selected to feed infants as they did. These unstructured, informal conversations helped to inform interview questions for both key informants for phase II and mother participants for phase III.

Observation sites. Participant observations took place in a variety of types of settings. The first type of settings were public sites where families interact in Tampa Bay. The primary four facilities where observations took place were Dinosaur World in Plant City; The Florida Aquarium, Glazer Children’s Museum and Lowry Park Zoo, which are all located in Tampa. These facilities were selected because they are popular among mothers of infants and small children. They each provide facilities to support infant care, including changing stations in their bathrooms, designated private spaces for mothers to care for infants, and some even have a microwave and diaper supplies available for use. One facility in particular has a private room
with a door lock available to families that includes a microwave, a changing station, a rocking chair. These sites are frequented by the target population because they have implemented measures to demonstrate their support for mothers and infant care.

Each of these facilities was visited multiple times for approximately 2 hours per visit. Because these facilities are privately owned and maintained, these sites required an admission fee to enter. However, the vast number of young families of various racial and ethnic groups that frequent each of these facilities made these ideal locations for observing interactions between mothers and infants. My observations in these facilities were not planned or organized, nor were there planned interactions scheduled between mothers and me. Rather, I witnessed and noted natural interactions between mothers and their children. These facilities were regularly accessed by the study population and multiple interactions were noted.

Additionally, I visited two parks---Bartlett Park in St. Petersburg, FL and All Person’s Rotary Park in Brandon, FL---that appear to be frequented by African American mothers and their families. Both parks are located in racially and culturally diverse neighborhoods and have play facilities such as swings, slides, and playground equipment utilized by young families. Access to these facilities was open to the public and was free of charge, and similarly these interactions were unplanned, unstructured observations rather than planned interactions. Because observations in these settings were noted in public facilities, it was not necessary to disclose myself as a researcher nor to disclose the nature of my observations (this was in accordance with my Human Subject’s research approval).

The second type of settings were private groups for mothers and children under five years of age that meet for shared interactions. The purposes of these meetings were to offer support, clinical treatment and/or education on breastfeeding, infant care and parenting strategies. I
sometimes introduced myself (or was introduced) as a mother who breastfed two children, as a lactation counselor or as a breastfeeding advocate. I always introduced myself (or was introduced) as a graduate student at University of South Florida. In some settings, I sat apart from the mothers and took notes of my observations. Other times, I was invited to engage in the conversations and share my experiences and offer guidance to others. At most meetings I attended, the participants and I shared conversation while the participants attended to their regular child care activities. I watched the mothers care for their children with activities such as breastfeeding, bottle-feeding, feeding of other foods (to older children), burping, changing diapers, changing clothing, singing, rocking and soothing their children. I sometimes offered my help to mothers when their hands were full taking care of their children. I found myself changing diapers, holding babies, and even rocking a baby to sleep on more than one occasion in an attempt to be helpful to mothers when I could.

The private group meetings I attended were free of charge. These support group and educational meetings were hosted by private organizations in public settings. Some were open to mothers and infants of all racial and ethnic backgrounds. Others had the stated purpose of offering support and education for Black mothers and families, and these groups were advertised to their target populations through their Facebook pages and by word of mouth. To this end, I never witnessed a mother of any background being turned away from any meeting, though were were clear patterns of attendance.

**DATA COLLECTION – PHASE II – KEY INFORMANT INTERVIEWS**

A non-probability, purposive sampling approach was used to identify key informants for this research phase. Key informants---birth and breastfeeding experts who work with African American mothers---were targeted. Bernard (2011) explains three criteria for using non-
probability sampling: (1) labor intensive, in-depth studies of a few cases, for which selecting key informants must be purposeful rather than random; (2) when a probability sample is not an option, in which case the bias should be documented; and (3) when collecting cultural data, then expert informants rather than randomly selected respondents is needed. According to Bernard, purposive sampling is used widely in several instances, including intensive case studies in which the objective is to identify and describe a cultural phenomenon, such as why African American women are the least likely among American women to breastfeed their children. Purposive sampling is also used widely when trying to identify hard-to-find populations. Experts who work with African American mothers and who can explain the cultural phenomenon that appears to be specific to them and not to other groups qualified this study for non-probability, purposive sampling.

**KEY INFORMANTS INCLUSION CRITERIA**

Informants who met study criteria for target enrollment included individuals from organizations that either: (1) have a proven record of increasing breastfeeding rates among African American mothers, or (2) provide breastfeeding and infant care education or support to African American mothers in Tampa Bay. Key informants were targeted who worked in positions that specifically interact with mothers at the late stages of pregnancy and/or the early stages of motherhood. The roles (although not all are paid in their capacities) of key informants included lactation counselors, nurses, midwives, obstetrician/gynecologists, trained volunteers (who lead support group), health educator and postpartum doula. Seven of the fifteen key informants who participated held more than one role, such as lactation counselor/nurse or OBGYN/researcher.
RECRUITMENT AND INTERVIEW STRUCTURE

Both local and nationally recognized organizations who have professionals working in the positions noted above were contacted and sent a copy of a research flyer (see Appendices 1 and 2) that explained the nature of the study, the criteria for key informants and my contact information. These organizations were targeted because they are nationally recognized experts on supporting, educating and encouraging African American mothers to breastfeed. They employ strategies that have been successful in increasing breastfeeding rates among these mothers in their respective communities.

Additionally, key informants were sought from local organizations who are familiar with cultural infant care dynamics of African American mothers who reside in Tampa Bay. Local key informants who participated in the study work in a variety of organizations, including medical offices, state and local government, higher education settings, and as volunteer educators and health advocates.

Key informants were invited to participate in interviews through one of several mechanisms. National key informants selected to participate either via video teleconference or by telephone call. Due to proximity, none of the national key informant interviews could be conducted face to face. Local key informants selected to participate via face to face interview or by telephone when a meeting was not convenient for them or possible. Because this research was exploratory and is not being used for comparative purposes, fifteen key informant interviews, some national and some local, were conducted based on suggested ranges between as few as six and as many as thirty-six informants (Guest, Bunce & Johnson 2006).

Interviews were semi-structured and utilized a pre-determined key informant questionnaire with open-ended questions (see Appendix 3). All but one interview was completed.
in under sixty minutes, with one extending for close to two hours due to the informant’s
enthusiastic desire to continue speaking. All interviewees were given a copy of an approved
verbal informed consent form and the form was also read out loud to each participant.
Informants were then asked whether they had any questions and were asked to provide a verbal
“yes” consenting to participate in the study. I created an electronic copy of each questionnaire at
the start of each interview and typed the responses provided by each informant to each question.
When it was possible, the interviews were also recorded using a digital voice recorder to improve
efficiency and minimize perception bias (Aunger 2004).

**KEY INFORMANT INTERVIEW QUESTIONNAIRE**

I developed a key informant questionnaire (see Appendix 3) in order to assess the
experiences and interpretations of key informants of the early motherhood experience of African
American mothers. This questionnaire contained two screening questions and eight content
questions. The two screening questions were asked to determine the suitability of including the
professional in the study. Informants were asked to identify how they worked with African
American mothers by subject area and job title. They were also asked to identify the populations
with whom they work to ensure their role as a subject matter expert on early mothering
experiences of African American mothers.

The content questions were divided into categories to correspond with the research
questions: 1) ascertain African American women’s primary values as mothers of young infants,
2) uncover messages that may discourage breastfeeding, 3) learn what influences breastfeeding
behavior and 4) determine elements of strategies that successfully increase breastfeeding
behavior. Questions were structured to ask key informants for their experiences and opinions
specific to their professional insights into what influences the early experiences of African

63
American mothers. However, they were open ended in their design to allow informants to share information that may have fallen specifically outside the questions but which the informant deemed relevant. Finally, the last question was an open ended question that allowed the informant to share any additional information that they felt was pertinent to the topic.

**DATA COLLECTION – PHASE III – MIDDLE CLASS AFRICAN AMERICAN MOTHERS (MCAM) INTERVIEWS**

A non-probability, respondent-driven sampling approach was utilized to identify MCAMs for this phase of research. This population met the same criteria outlined above by Bernard for when to utilize non-probability sampling. To reiterate, Bernard explains why purposive sampling is used widely when the objective is to identify and describe a cultural phenomenon, such as why African American women are the least likely among American women to breastfeed their children, as well as when trying to identify hard-to-find populations. In addition, Guest (2006) indicate that while probabilistic sampling should be used whenever possible, purposive sampling is a useful and appropriate method when attempting to access hard-to-reach populations.

The purpose of phase III of this study was to learn the experiences and values of a designated subsection of the larger population of mothers. The specifics of this study required the use of sampling strategies that allowed me to target and identify mothers who met the specific criteria, as random sampling techniques would not have enabled access to this population or the information uncovered.

**MIDDLE CLASS AFRICAN AMERICAN MOTHERS (MCAM) INCLUSION CRITERIA**

The target population of MCAMs were adult women age 18 or older. Additionally, study participants needed to meet the criteria of the categories detailed below.
Identify as “Black/African American.” While racial group categories frequently do not nuance Blacks into subgroups such as African American, Caribbean American or recent African immigrant to the United States (Cricco-Lizza 2007), this research focused on mothers with shared American histories and was therefore limited to those born in the United States who self-identify as “African American/Black.” Health experiences and health outcomes are reportedly similar for foreign-born Blacks compared with native-born Blacks after approximately fifteen years of residence (Singh & Siahpush 2002). For this reason, being born in the US and self-identifying as African American/Black was sufficient for determining the population for this study. Mothers whose primary ethnic identity was other than “African American” or “Black” (such as “Caribbean,” “Haitian,” “African,” “Puerto Rican”) were excluded from this research.

Child of five years of age or younger. Participants were required to have given birth to a child within five years of the start of the study, or to have been born since July 2012. Mothers of multiple children were invited to participate as long as the youngest child was five years of age or younger, as they were only asked to recall infant feeding experiences of the youngest child.

Middle class and above. Income was used as a proxy to determine social class. Mothers who met criteria for the study had a household income that exceeded the eligibility guidelines for Women, Infant and Children (WIC). A number of studies of infant feeding choices of “low-income” women define their target population based upon meeting WIC income eligibility criteria (Caulfield et al. 1998; Guttman & Zimmerman 2000; Kaufman et al. 2009; Lee et al. 2009) or based upon having a household income beneath the federal poverty level (Underwood et al. 1997). To be consistent with this criteria, participants who qualified for participation were determined to exceed WIC income limits for 2015, also defined as 185% US poverty levels (see table 3-2).
**Table 3.2. 2015 Women, Infants and Children (WIC) Income Eligibility Guidelines**

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Annual</th>
<th>Monthly</th>
<th>Twice-Monthly</th>
<th>Bi-Weekly</th>
<th>Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$21,775</td>
<td>$1,815</td>
<td>$908</td>
<td>$838</td>
<td>$419</td>
</tr>
<tr>
<td>2</td>
<td>29,471</td>
<td>2,456</td>
<td>1,228</td>
<td>1,134</td>
<td>567</td>
</tr>
<tr>
<td>3</td>
<td>37,167</td>
<td>3,098</td>
<td>1,549</td>
<td>1,430</td>
<td>715</td>
</tr>
<tr>
<td>4</td>
<td>44,863</td>
<td>3,739</td>
<td>1,870</td>
<td>1,726</td>
<td>863</td>
</tr>
<tr>
<td>5</td>
<td>52,559</td>
<td>4,380</td>
<td>2,190</td>
<td>2,022</td>
<td>1,011</td>
</tr>
<tr>
<td>6</td>
<td>60,255</td>
<td>5,022</td>
<td>2,511</td>
<td>2,318</td>
<td>1,159</td>
</tr>
<tr>
<td>7</td>
<td>67,951</td>
<td>5,663</td>
<td>2,832</td>
<td>2,614</td>
<td>1,307</td>
</tr>
<tr>
<td>8</td>
<td>75,647</td>
<td>6,304</td>
<td>3,152</td>
<td>2,910</td>
<td>1,455</td>
</tr>
<tr>
<td>Each Add'l family member add</td>
<td>+$7,696</td>
<td>+$642</td>
<td>+$321</td>
<td>+$296</td>
<td>+$148</td>
</tr>
</tbody>
</table>


**Infant feeding categories.** Mothers were categorized into one of two groups: mothers who breastfed (MBF) and mothers who formula fed (MFF). The two groups were determined based upon the many benefits that are attributed to breast milk.

The question of how to define breastfeeding has been addressed by anthropologists. Human breast milk is considered to be the best form of infant nutrition. The World Health Organization (1981) describes breastfeeding as “an unequalled way of providing ideal food for the healthy growth and development of infants” and “a unique biological and emotional basis for the health of both mother and child” (p. 6). Furthermore, it states that “the anti-infective properties of breast milk help to protect infants against disease” (p. 6). Infant formula, an artificial milk product that mimics the properties contained within breast milk, was developed as a substitute for mothers who are either unable or choose not to breast feed. While it contains a
number of properties also contained in breast milk, it lacks many of the nutritional contents and beneficial properties within human breast milk (WHO 1981).

While other aspects of the mother-infant dyad have been argued to be critical, the term breastfeeding is defined and defended as a valuable act primarily because of the benefits imparted to mother and baby due to baby’s consumption of mother’s breast milk (Dieterich et. al 2013). Based on Thulier’s definition below (2010), participants were asked to select the most appropriate feeding group category for their infant. Mothers who initiated breastfeeding and continued for a minimum of thirty days were considered “mothers who breastfed” (MBF). By self report, mothers included in this study were those who identified with Thulier’s definition below for exclusive breast milk, whether the baby latched onto a woman’s breast or was fed breast milk from a bottle.

Mothers who never initiated breastfeeding or who initiated breastfeeding and switched to formula within the first three days of the baby’s life were considered “mothers who formula-fed” (MFF). A few mothers who initiated breastfeeding did so under the strict advisement of the hospital but had already stopped nursing and switched to formula before leaving the hospital, never having had the long term intention to breastfeed. By self report, mothers included in this study were those who identified with Thulier’s definition below for exclusive artificial milk.

Mothers who fell into the categories between and who breastfeed for longer than three days but who did not breastfeed for the first thirty days were excluded from this study. This was to ensure that both groups of mothers were as representative as possible of two separate and exclusive groups of mothers: those who breastfed and those who formula fed. To minimize cross over between the two groups, mothers who Thulier defined as “predominate breast milk” (75%
or more of total diet from breast milk), “mixed feeding” (25-75% of total diet breast milk) or “predominate artificial milk” (75% or more of total diet from formula) were excluded.

**TABLE 3.3. PROPOSED FEEDING GROUPS**

<table>
<thead>
<tr>
<th>Feeding Practice</th>
<th>Requires the Infant Receive</th>
<th>Allows the Infant to Receive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breast milk</td>
<td>Breast milk only (from mother, wet nurse, or donor)</td>
<td>Drops, syrups (vitamins, minerals, medicines)</td>
</tr>
<tr>
<td>Predominant breast milk</td>
<td>Breast milk (&gt;75% of diet)</td>
<td>Water, juice, artificial milk, or solid food</td>
</tr>
<tr>
<td>Mixed feeding</td>
<td>Breast milk (25-75% of diet)</td>
<td>Water, juice, artificial milk, or solid food</td>
</tr>
<tr>
<td>Predominant artificial milk</td>
<td>Artificial milk (&gt;75% of diet)</td>
<td>Water, juice, breast milk, or solid food</td>
</tr>
<tr>
<td>Exclusive artificial milk</td>
<td>Artificial milk only</td>
<td>Drops, syrups (vitamins, minerals, medicines)</td>
</tr>
</tbody>
</table>


**RECRUITMENT AND INTERVIEW STRUCTURE**

My target enrollment was a total of fifty mothers (N=50), based on suggested ranges between as few as six and as many as thirty-six informants (Guest, Bunce & Johnson 2006). I was able to interview 43 mothers: 23 mothers who breastfed their infants (MBF) and 20 mothers who formula fed (MFF). I began to identify and recruit African American mothers who met the criteria above after conducting a number of interviews with key informants. Many of the key informants agreed to allow me to recruit from their patient or client populations. I created a flyer (see Appendix 2) that I shared with all of the key informants I interviewed and asked that they share with mothers who met the criteria. Six key informants allowed me to provide additional copies of my flyer which they distributed to clients. Two key informants have a private Facebook group for African American mothers in Tampa Bay and shared my flyer with the members of the group (and also invited me to become a member). Another two facilitate regular support groups to support breastfeeding and infant care for mothers (three groups in total), one of
which had multiethnic mothers and two of which were exclusive to African American mothers. Additionally, one group with whom I am affiliated is a local chapter of an organization of African American mothers in Tampa Bay. I shared the flyer with this group and identified four mothers who met criteria for MBF. Identifying MBF was a task that I expected to be very challenging, but it was a relatively easy task in the sense that the key informants were well connected with breastfeeding mothers who were willing to speak with me and share their stories. 19 of the 23 MBF were recruited through the key informants I interviewed. The remaining 4 MBF were members of the local chapter of the organization of African American mothers in Tampa Bay.

Identifying MFF, on the other hand, was a comparably difficult task. This was in part because of how strict the criteria were for the study. I encountered a number of African American mothers who fulfilled Thulier’s criteria for either mixed or partial feeding, but identifying mothers who nearly exclusively formula fed their children was challenging. Eight of the twenty MFF were identified through key informants, but the other twelve were identified in two alternate forums. Seven of the MFF were members of the local chapter of the organization of African American mothers in Tampa Bay. The remaining five mothers were referred from other mothers I interviewed: two were related to MBF and three were referred by MFF. I spoke with a total of 20 MFF.

Interviews were semi-structured and utilized a pre-determined questionnaire for MCAMs with open-ended questions (see below for details). Interviews took between 30 and 90 minutes each, with the exception of two interviews that took longer due to the mothers stopping to care for their children during the interview. I also offered assistance to mothers during the interviews, and often was invited to help hold babies, change diapers, prepare bottles of milk (both breast
milk and formula), microwave lunches, wash dishes and load children into car seats at some point during the interviews. In one case, I even helped little ones work on an art project that involved play-doh!

All MCAMs were given a copy of an approved verbal informed consent form to read at their leisure, and I also read the form out loud to each participant. Mothers were then asked whether they had any questions and were asked to provide a verbal “yes” consenting to participate in the study. I created an electronic copy of each questionnaire at the start of each interview and typed the responses provided by each informant to each question. When it was possible, the interviews were also recorded using a digital voice recorder to improve efficiency and minimize perception bias (Aunger 2004). This proved a helpful strategy in instances when I assisted mothers with caring for their children. In instances when there was a lot of background noise from children, television playing, and others speaking, my note taking was much more reliable than recording the interviews.

**MCAM Interview Questionnaire**

I developed a questionnaire for MCAMs in order to assess their experiences and interpretations of early motherhood for African American mothers. This questionnaire (see Appendix 4) contained four screening questions, ten background questions, and tent content questions. The four screening questions were asked to determine the suitability of including the mothers in the study (detailed above under “MCAM inclusion criteria”). Once the mother was identified as meeting the criteria for inclusion, I asked her questions to learn the details of her background. These questions included asking their education level, age at the birth of the youngest child, about their other children if they have any, who lived in the house when the baby was born, and where the baby was born. I also asked whether she was employed at the time of
her baby’s birth and her employer’s response to the pregnancy, as well as details about caring for
the baby including who cared for the baby as a newborn and how the baby was fed.

Similar to the key informant questionnaire, the content questions were divided into
categories to correspond with the research questions: 1) the mother’s primary values for her
infant, 2) perceived messages that discourage breastfeeding, 3) external influences on caring for
the baby and 4) what they consider to constitute successful parenting. Questions were structured
to ask MCAMs for their experiences into what influences the early experiences of African
American mothers, and included probes as relevant to solicit more details. The questions were
open ended in their design to allow mothers to share information that they deemed relevant to
their experience as mothers. Finally, the last question was an open ended question that allowed
the mother to share any additional information that she felt was pertinent to the topic.

DATA ANALYSIS

PARTICIPANT OBSERVATION

Analysis and summation of the field notes taken during my participant observation was
the first step. The purpose of taking field notes was to collect my observations so that I could
describe the environment frequented by African American mothers and their infants, to detail
African American mothers’ experiences within the various settings and to outline how these
settings may have influenced the mothers’ decisions on how to feed their children. To begin, I
reviewed the notes taken at each site and also reviewed the maps I drew of each site. As I
became familiar with the notes, I drafted an ethnographic account, which includes a descriptive
summary of each facility and my experiences observing and interacting with mothers there. The
ethnography creates a foundation for contextualizing how African American mothers experience
infant feeding to understand the details provided in the next phases of data collection.
INTERVIEW DATA

My analyses of the key informant and MCAMs interview data were similar. I followed Bernard’s description of the grounded theory approach to data analysis (2011), developed by sociologists Glaser and Corbin for the analysis of ethnographic interview data. Per Bernard’s description, I began by transcribing the recorded interviews and reading through the notes taken during each interview, meeting and in the field. I spent a considerable number of hours with this stage to establish familiarity with each set of interview data before then identifying ideas that emerged from the data. I then created a code for each idea that emerged and had a total of 109 codes between the two sets of interview data: 47 codes for the key informant interviews and 62 codes for the MCAM interviews. Each codebook contained largely descriptive codes which I was able to further consolidate to identify categorical themes that were consistent with the codes created within each interview guide. I went through several iterations of coding to condense the findings until the major themes were identified. I then used a process of in vivo coding to identify direct quotations in the interview transcripts and my notes that supported these themes. To ensure that during the process of analysis I did not project my own bias or misidentify a code, I continually referred back to the transcripts and re-examined my interpretation of the data. With each wave of coding, I became more grounded in the data and more clearly was able to identify the larger themes that emerged from this data. The analysis resulted in articulating the themes identified by key informants and by MCAMs, which were similar in most cases but were unique to each group in other cases.

CONCLUSION

This research was conducted over a period of ten months. Data collected included participant observations taken at six public facilities and three types of private support group
meetings for mothers. Additionally, I conducted interviews with fifteen key informants (n=15) and forty-three (n=43) middle class African American mothers for a grand total of 58 interviews. Using participant observation methods that included ethnography, quiet observations, interactive observations and semi-structured interviews allowed for a thorough understanding of African American mothers’ experiences in the early infancy stage, how they defined “good motherhood” and the values that influenced African American mothers’ decisions for how to feed and care for their infants.
CHAPTER FOUR: PHASE I FINDINGS – FEEDING IN SECRET

INTRODUCTION

Research was collected in three sequential phases. The first phase was to observe the interactions of Black and African American mothers and their children in public locations. The second phase was to interview key informants who are familiar with the experiences of African American mothers and with the factors that influence their decisions on feeding and infant care. The third phase was to interview middle class African American mothers (MCAMs) who either breastfed their children and fed their children infant formula to learn their insights into what influenced those decisions, to learn more about their early experiences of motherhood and to learn what these mothers valued most during that time.

As a mother, I had the opportunity to visit many of these settings with my own children in previous years. When I became a lactation counselor, however, I became even more aware of the interactions between mothers and infants, and I noticed that places that draw families such as parks more often had mothers who breastfed on site than places such as a grocery store or shopping mall. I was excited to study and explore these sites now as a researcher. My memories of the details differed from the observations I made during this study. I had underestimated the number of families and the spaces within each of the facilities utilized specifically by mother with their infant babies. This chapter presents an ethnographic account from public observations of Black mothers of young children in Tampa Bay.
PARTICIPANT OBSERVATIONS AT PUBLIC SITES IN TAMPA BAY

The first type of settings were sites where families interact in Tampa Bay. I selected six public locations in which to observe families. The first four were facilities frequented by middle class families and required paid fees upon entry, including Dinosaur World in Plant City; The Florida Aquarium, Glazer Children’s Museum and Lowry Park Zoo, which are all located in Tampa. Two additional sites where observations took place were Burnett Park in St. Petersburg and All Person’s Park in Brandon, both parks with free access and open to the public.

Though I had done considerable observation at the fee-for-entrance sites in preparation for this research in order to determine the suitability of this as an observation site, I visited each site twice during the study period. I went to the first two fee-for-entrance facilities---Glazer Children’s Museum and Lowry Park Zoo---alone and I was met with a couple strange looks. I could understand the suspicions that mothers may have felt in being observed by a woman who was alone. Since I am a mother, I decided to take my children for the other visits, and I did not notice any further strange looks. I believe this may have helped me to appear less suspicious as I watched mothers and their children interact and may even have encouraged opportunities for interaction with mothers.

GLAZER CHILDREN’S MUSEUM

I started at Glazer Children’s Museum. It is an indoor museum with two levels of exhibits with which children can interact and play. Each floor has high ceilings, wall to ceiling windows and video cameras throughout the museum. On the first floor, there is a large open water exhibit that is surrounded by Adirondack chairs, with a large toddler play area to the side. Everything is wide open so that parents can observe their children from across the room, which is important in cases where a mother has an infant or toddler in the toddler play space and an
older child at the water exhibit. Like all of the sites where I did observations, it is usually well attended, even on school days, by mothers and infant children.

The second floor has rooms specific to each theme: a Publix grocery store, a weather station, a fitness room, construction zone, a fire station, and a toddler area with a ball pit. Each of these areas has a number of benches and places for mothers to sit. It was in the toddler spaces that I observed mother and infant dyads.

I counted a total of twenty-three mothers with small babies between my two visits, five of whom were Black mothers. Black mothers who frequented these spaces pushed large strollers that were adorned with baby carriers, diaper bags, toys, and food and drinks for their older children. Some wore their babies in baby carriers and others simply held babies in their arms. All of the mothers were observant of their children and played patiently with them at the various toys and exhibits. The biggest differences were evident when it came to feeding.

I witnessed eleven of the twenty-three mothers breastfeeding their babies. Some of the mothers very comfortably arranged their babies around their bodies or onto the chairs to breastfeed, but most mothers simply held their babies in their arms and fed them. I did not see the mothers go to any extraordinary efforts to cover themselves up or to hide from others. There were not many men around, but the space was open, crowded and video cameras to monitor the museum can be seen in the corners of the ceiling. Still, five of the mothers pulled out cover ups before nursing their babies. A cover up is a small sheet of material with a device at the top that allows the small sheet to be draped over the front of the mother’s body and fastened around her neck. When an outsider looks to the mother, they would not be able to see her breasts or see the baby being fed.
One of the eleven mothers who breastfed was Black, and she was also one of the mothers who used a cover up. In addition to using a cover up, I noticed that she had gathered her children close to the area where she sat. With her children close by, she did not have to stand to watch her children play like the other mothers did. Unlike the other mothers who breastfed while standing, walking and watching their children, she was seated in a chair against the wall of the toddler play area. Unless a person was specifically observing like I was, they might have missed the fact that she was breastfeeding.

The other four Black mothers pulled out bottles at various times to feed their babies. I watched with fascination as they multitasked watching their children, pulling out pre-filled bottles and feeding their babies, and sometimes even changing diapers on their laps. Although I never had an opportunity to speak with the mother who breastfed at the Children’s Museum, I did have a brief encounter with one of the Black mothers who bottle fed. I noticed this mother had a breast pump in her stroller, and I asked her whether she thought it was worth purchasing. “For sure,” she said. “Without it, these trips with my children would be too short to make driving worth it because I’d be running to the car every hour.” I told her that I had seen other mothers breastfeeding there so she probably could too, if she wanted. She answered that she only nurses at home, in the car and on occasion in the bathroom. She went on to say that she did not understand how women could “whip their boobs out so freely in public with so many people around.” She was a breastfeeding mother who made a point of not breastfeeding in public.

Tampa’s Lowry Park Zoo

Lowry Park Zoo is the premier site for seeing a wide range of wild animals in Tampa. The Zoo is award winning for its design, and it is also a favorite among mothers. There are frequently groups of mothers and children who use it as a site for playdates and meet ups,
including two groups of which I was a member when my children were younger. Besides numerous animals, including lions, tigers, gorillas, penguins, zebras, elephants and more, Lowry Park Zoo also has many rest areas interspersed amongst the exhibits. Around almost every corner there is a quiet, hidden space with park benches, tables and chairs. One section, Wallaroo Station, houses a petting barn, a roller coaster, several small rides for toddlers, a small water play space for toddlers which is crowded in the summer time, a restaurant, a bathroom and other exhibits. The restaurant has tables in the shade, some of which are more hidden from view than others, where mothers and children congregate to eat and rest. One side of this restaurant also has a vending machine that sells diapers and baby wipes in addition to snack foods, drinks, suntan lotion and other items. Though families disperse throughout the Zoo, this particular space tends to be a gathering space for mothers and young children in particular.

I spent the majority of my time observing in Wallaroo Station, though twice during these visits I spotted mothers—one appeared to be White and the other was Asian--walking around the Zoo breastfeeding babies. The Asian mother carried her baby in a baby carrier and nursed while walking with her family. The other mother had the baby in her arms and was rocking and nursing the baby while tending to an older child as what appeared to be her spouse pushed a stroller behind her. In total, I observed twelve mothers with babies between my two visits, and three of these mothers were Black. Four of the twelve mothers breastfed within my purview, and they did not appear to be trying to hide nursing their babies. None of these mothers, however, was Black. I witnessed two Black mothers bottle feed their children with milk that could easily have been breast milk or formula. One of the Black mothers carried her baby in a carrier and could have even discreetly nursed as I have witnessed other mothers do, but I did not see this occur.
**THE FLORIDA AQUARIUM**

The Florida Aquarium is popular during the summer months because it is an air-conditioned, indoor facility that also has an outdoor water play area for toddlers called The Splash Pad. During my visits in early Summer 2017, there were a number of mothers present with children who had worn or brought along swimsuits and towels so they could enjoy the Splash Pad after touring the aquarium. Unlike during the school year, there were also a number of fathers and other males present. There were groups of families at the Aquarium rather than just mothers and young children since older children were out of school for the summer. Additionally, there seemed to be more extended relatives present.

Similar to the Museum and the Zoo, the Aquarium has seating available throughout the facility that is well utilized by mothers and children, both of whom are the most consistent patrons. It is a three level facility with numerous tanks and stations that house birds, ducks, snakes, sharks, giant grouper, otter, lobsters, crabs, sting ray, sea horses, turtles, starfish, sea anemone and more fish and aquatic life than I can identify. There is a main walkway that the patron can follow which takes you past every tank and exhibit. Around each of these exhibits are benches, tables and chairs, and also white wooden rocking chairs. Some are in full view of the walkway and others are hidden around corners. It was not uncommon to see mothers rocking infant children in the rocking chairs whether in full view or tucked away.

Between my two visits to the Aquarium, I spotted twenty-two mothers with babies. Many of these mothers also had other children, but a few appeared to have just one child. In some instances, the older children were watched by another adult in their party or entertained themselves when the mother sat nearby to care for the baby. I witnessed eight mothers breastfeed throughout the Aquarium in one of the rocking chairs. Five mothers used cover ups
which kept their bodies covered up. Additionally, one mother who appeared to be White nursed her baby inside a carrier. I would have missed noticing that she was nursing a baby if I had not seen her latch the baby, meaning to attached the baby for feeding, before adjusting the carrier to cover herself.

Four of the mothers with babies appeared to be Black. Once again, I did not see any of the Black mothers breastfeed. Two of the mothers pulled out bottles to feed their babies while the older children sat close by to eat lunch. This does not mean that the other mothers did not breastfeed, however. The Aquarium has an infant care room on the first floor that is well known by the mothers who frequent the facility. During both visits, I saw the door had a small red sign above the door handle confirming that it was locked and at least one mother and baby waiting for the room to become available. Though many mothers seemed to feel comfortable breastfeeding publically in the Aquarium, it is possible that some of the mothers chose to breastfeed in the privacy of the room, including the Black mothers.

Dinosaur World

Unlike the other three facilities in Tampa, Dinosaur World is located in Plant City, just a few miles east of Tampa proper. This facility is much less crowded than the others for several reasons. Besides being outside of the city, it does not have any rides, a water park or restaurants. There are a few exhibits and a small museum, but they are mostly self-guided. To enter the park, one must walk through the gift shop before walking back outside into the park. There is a large outdoor space with two play yards: one for children under age 6 and the other for children over 6. The small play yard has small climbing structures and two slides for small children. The large play yard has regular swings, tire swings, several climbing walls, a giant jungle gym with multiple slides and ways to climb up and down. This space also holds the first of many
enormous dinosaur replicas stationed all around the park. Beyond the play yard, dinosaurs are situated among tall green trees and low grassy plants. Windy walkways carry visitors through the park around many hidden rest spots, benches, chairs and tables, and picnic tables where families can eat the lunches or snacks they bring from home.

I selected Dinosaur World because it is a smaller, family owned facility that is frequently visited by mothers and children, especially during the week in the morning hours. It is safe and quiet, and its prices make it more accessible to a wider range of families. On the two days I conducted my observations, I counted seventeen mother and infant dyads, some of which included other children and spouses. I observed only two of the mothers breastfeed their infants by the large play area, and one of these mothers appeared to be Hispanic. She was surrounded by family and was seated in a corner covered with either a large blanket or a cover up.

Four of the sets of mothers with infants I counted between the visits were Black mothers. One Black mother was breastfeeding as I rounded a corner towards a group of tables. Interestingly, when she saw me, she quickly turned away and stopped feeding the baby. I was with my daughters and made a point of politely looking to offer her some privacy. I was never clear about whether she stopped feeding her baby because we arrived or because she was done feeding the baby, but unfortunately she left the area not too long after. The other three mothers did not feed their babies in my presence. Instead, they spent much time playing with their children and either holding their infant child or pushing him or her in a stroller.

BARTLETT PARK, ST. PETERSBURG

I learned about Bartlett Park from a key informant, a certified midwife whose practice is on the peninsula that sits about ten miles west of Tampa in St. Petersburg. After our interview, she mentioned that a good place to observe mother-infant dyads publically was this park, which
was just a few blocks from her work place. I read reviews of the park before I visited to get a sense of what the park would be like before visiting. Reviews describe the park to be in an unsafe neighborhood, but I did not find this to be the case.

Bartlett Park is a beautiful, spacious and clean park. It has waterfront access on one side for water enthusiasts, and it also has tennis courts and two fields where I saw teenage boys playing soccer. The children’s play area is outfitted with fairly recent play structures on which my children enjoyed playing. This is where I conducted my observations both days we went to Bartlett.

One factor that made this park ideal for my observations was the large number of Black families at the park. It is situated in what appears to be a mixed race neighborhood, but I saw many Black mothers and children using the play area and the soccer field. It also appeared to be a place for young Black mothers to hang out, as most of the mothers with babies I saw appeared to be teenagers or young women.

I spoke with a Black mother who I will call Yvette. She was a 20-year old mother of a four-week old boy and a three-year old girl with whom my daughters played during our visit. It was summertime and hot, and the baby wore a onesie as he sat in his baby carrier on top of a picnic table. When Yvette pulled out a bottle to feed the baby, I asked her if he was a good eater. She responded that he was such a good eater that she “had to stop breastfeeding him” because he was “biting her raw.” We began to speak in earnest about breastfeeding technique and latching, and as a certified lactation counselor (CLC) myself I could tell that Yvette had learned a bit about breastfeeding during the time she fed her son. She did not breastfeed her daughter and wanted to give it a try with her son. It turned out that Yvette delivered her son with the midwife who suggested I do observations in this park. The midwife encouraged all her clients to
breastfeed which was why Yvette did so early on, but it was harder and more painful than she expected it to be. I asked if she reached out for help when she began to struggle with nursing, and she said that her mother told her it would be easier to switch to formula than to wait for help to show up. The young mother breastfed him for about a week, but she seemed happy with her choice to switch to formula. He had gained weight since birth and slept peacefully while we spoke except when he drank his milk.

I asked whether she knew any mothers who breastfed, and she said she had one relative who breastfed all of her children. This relative was an anomaly in her family, and I got the sense that she was often the butt of family jokes for having opinions on parenting that were outliers. Yvette described the relative as “the one who makes all her kids food, uses cloth diapers, wears a baby carrier, you know the type.” I asked whether she had any other friends who were that type of mother, and she told me no. “It’s hard to be that kind of mom in my family because my family is close and my mama and grandmamma believe in the old ways.” She went on to say that “the old ways” included feeding the baby as much as the baby would take, and adding cereal to the bottle at around three months old to keep the baby growing well and sleeping through the night. One problem Yvette had during her short stint breastfeeding was that the baby woke more often to eat. I asked if she thought that was abnormal, and she said it was because the women in her family were “good at getting babies to sleep through the night early on.” She was grateful that he slept more with formula than he had while breastfeeding because she planned to go to school. Formula feeding, she explained, would make it easier to leave the baby with her mama and grandmamma while she was in school.

I did not speak with any other mothers that afternoon, but I did see two other mothers with young infants during this visit and four more during my next visit. Four of the seven
mothers appeared to be Black, and the other three appeared to be White (2) and Hispanic (1). I did not see any of the mothers breastfeed their babies in the park, but five of the seven fed their babies milk from bottles. My proximity from each of the mothers made it impossible to spot any details to help me determine whether they were fed breast milk or formula.

**All Person’s Rotary Park, Brandon**

My daughters have played many times at All Person’s Rotary Park. It is a popular park in the Brandon area, which is about five miles east of Tampa and ten miles west of Plant City. All Person’s Rotary Park has two large play areas, one for older children and one for younger children. It has swings, slides, jungle gyms with crawl spaces and activities, as well as a sand pit. Behind the play area is a large splash pad covered in fake grass where streams of water shoot up from the ground. While the water play area is wide open to the sunlight, the play areas are covered by large trees and tree leaves. This park is a favorite in the summertime due in part to the shade provided by the trees and also due to the park design and layout.

The community surrounding All Person’s is mixed, not just racially but also socioeconomically. It is a favorite spot of mothers and young children, as are the other sites where I conducted observations. This park is often occupied during the week while older children are in school, and it is not uncommon for groups of mothers to have play dates and meet ups at this park.

I counted sixteen mothers with infants on my first visit and eleven on my second. During my first visit for conducting participant observation, I happened to visit while a group of Black mothers were out with their children. There were five Black mothers the first day, and I could not tell whether the women were related or were friends. I tried to make conversation with one mother, but the groups seemed to be leaving as I arrived. However, none of the Black mothers
breastfed in my presence. I counted two Black mothers and infants during my second visit (for a total of seven Black mothers between the two visits) and I never saw those mothers feed those children at all.

Three of the other mothers did breastfeed; two appeared to be White and one was Hispanic and spoke Spanish to her older children. Both of the white mothers used cover ups and spoke to another mother while nursing. The Hispanic mother was not using a cover up, but she had the baby cleverly arranged so that her body was not exposed. In total, I only witnessed three mothers breastfeed at All Person’s Park. Given the numbers of families, older children and males who were present, it did not surprise me how few of the mothers breastfed at the park. Additionally, the park was very busy on the days I did my observations and it is entirely possible that I missed a mother breastfeeding her child that day.

**SUMMARY OF OBSERVATIONS AT PUBLIC SITES**

Between twelve visits and twenty-four hours of observation, I was able to observe 108 mother-infant dyads (or pairs) across six observation sites.

At the Glazer Children’s Museum, I observed twenty-three dyads. Of these, five (21.7%) were Black and eighteen (78.3%) were other races. Eleven (47.8%) of these twenty-three dyads were mothers who breastfed. Only one of the eleven MBF was Black.

At Tampa’s Lowry Park Zoo, I observed twelve dyads. Three (25%) were Black and the nine (75%) were other races. Four (33%) of these twelve dyads were MBF, none of which were Black mothers.
At The Florida Aquarium, I observed twenty-two dyads. Four (18.2%) were Black and eighteen (81.8%) were other races. Eight (36.4%) of the twenty-two dyads were MBF, none of which were Black mothers.

At Dinosaur World, I observed seventeen dyads. Four (23.5%) were Black and thirteen (76.5%) were other races. Two (11.8%) of the seventeen dyads were MBF, and one of these two mothers was Black.

At Bartlett Park, I observed seven dyads. Four (57.1%) were Black and the remaining 3 (42.9%) were other races. None of those mothers breastfed publicly.

At All Person’s Rotary Park, I observed twenty-seven dyads. Seven (25.9%) were Black and twenty (74.1%) were other races. Three of the twenty-seven were MBF, and none of these mothers was Black.

**TABLE 4.1 SUMMARY OF MOTHER-INFANT DYADS AT OBSERVATION SITES**

<table>
<thead>
<tr>
<th>Observation Site</th>
<th>Mother-Infant Dyads</th>
<th>African American Dyads</th>
<th>Non-African American Dyads</th>
<th>Mothers Who Breastfed (MBF)</th>
<th>African American MBF</th>
<th>Non-African American MBF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glazer Children’s Museum</td>
<td>23 (100%)</td>
<td>5 (21.7%)</td>
<td>18 (78.3%)</td>
<td>11 (47.8%)</td>
<td>1 (4.3%)</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td>Tampa’s Lowry Park Zoo</td>
<td>12 (100%)</td>
<td>3 (25%)</td>
<td>9 (75%)</td>
<td>4 (33%)</td>
<td>0</td>
<td>4 (33%)</td>
</tr>
<tr>
<td>The Florida Aquarium</td>
<td>22 (100%)</td>
<td>4 (18.2%)</td>
<td>18 (81.8%)</td>
<td>8 (36.4%)</td>
<td>0</td>
<td>8 (36.4%)</td>
</tr>
<tr>
<td>Dinosaur World</td>
<td>17 (100%)</td>
<td>4 (23.5%)</td>
<td>13 (76.5%)</td>
<td>2 (11.8%)</td>
<td>1</td>
<td>1 (5.9%)</td>
</tr>
<tr>
<td>Bartlett Park</td>
<td>7 (100%)</td>
<td>4 (57.1%)</td>
<td>3 (42.9%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Person’s Rotary Park</td>
<td>27 (100%)</td>
<td>7 (25.9%)</td>
<td>20 (74.1%)</td>
<td>3 (11.1%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>108 (100%)</td>
<td>27 (25%)</td>
<td>81 (75%)</td>
<td>28 (25.9%)</td>
<td>2</td>
<td>26 (24%)</td>
</tr>
</tbody>
</table>

Black mothers comprised 25% of the mother-infant pairs I observed. While 25.9% of these mothers did breastfeed publicly, less than 2% of those mothers were Black. Public breastfeeding is not necessarily an accurate representation of breastfeeding. Just over one quarter of the mothers observed breastfed publicly. However, there is a large disparity between
Black mothers who breastfed publicly and mothers of other races. Whether this is a question of public feeding or all feeding is difficult to discern.

What I observed from the two Black mothers who did breastfeed was noted discomfort and hiding themselves from view. The other mothers I observed breastfeeding in public spaces did not seem uncomfortable nor did they hide themselves. Some mothers used cover-ups to cover their bodies from onlookers or nursed in a baby carrier which concealed her body, but these mothers continued to nurse their babies publicly and did not turn away or distance themselves from those around them.

Four of the six sites were heavily attended by mothers and children, and in some instances mothers breastfed in plain site which could have provided a sense of solidarity and safeness to any breastfeeding mothers to feel safe feeding their baby. Naturally, the lactation counselor in me hoped to see mothers comfortably out and about with their young, breastfeeding, changing diapers and caring for infants. While I did not anticipate seeing as many Black mothers breastfeeding as mothers of other ethnic groups, I did anticipate seeing some. I remembered breastfeeding my own children in some of these settings with a cover up, and being grateful for the ability to feed my baby on site offered an enormous amount of flexibility in my ability to schedule activities day to day. Not only did it provide me with the ability to engage in activities that would have precluded me otherwise, but there was a measure of freedom and even agency in being able to breastfeed wherever and whenever I deemed it appropriate.

The research does indicate that the majority of mothers of all studied ethnic groups breastfeed, and this includes Black mothers. I knew that mothers were less likely to breastfeed in public settings, although I was hopeful that in these settings that were so heavily frequented by
mothers and infants I would encounter an exceptional number of breastfeeding mothers. I was not disappointed in general to see mothers feeding their infants.

However, even in these safe and supportive circumstances, Black mothers were significantly less likely to nurse their young. One mother who confirmed that she does breastfeed made a concentrated effort not to breastfeed in a facility where other mothers clearly did. She was not against the act itself, but the public display made her uncomfortable. The question with which I was left was to determine whether this evidence supported the notion that Black mothers do not breastfeed or whether it indicates that they do breastfeed but prefer not to do so in public.

**PARTICIPANT OBSERVATIONS AT NEW MOTHER SUPPORT GROUPS**

**OPEN BREASTFEEDING SUPPORT GROUPS**

One setting where I was able to learn more about the infant feeding practices of Black mothers was in support group meetings for new mothers. I attended a number of meetings in which infant care support, education, and in some cases medical assistance was provided to mothers who struggled to breastfeed their children. Three groups of meetings were open to women of all races and two were exclusive to Black mothers.

The first meetings were sponsored by a national breastfeeding advocacy group that is well known throughout the United States. The meetings I attended in Brandon took place twice a month: a morning meeting occurred on the third Wednesday and an evening meeting occurred on the second Monday of each month. The meetings were lead by Trained Volunteers who, in some cases, have additional training as registered nurses (RN) and as International Board Certified Lactation Consultants (IBCLC). As Trained Volunteers, the group leaders are quite
knowledgeable in the latest science of lactation. They can offer support with breastfeeding techniques that include how to position the baby, how to determine an appropriate latch, and also sometimes troubleshoot problems mothers might encounter, such as breast tenderness, blockages, mastitis, slow growth in children and more. However, in their official capacity they offer support mother-to-mother based on their training and their experiences as mothers.

The meetings took place in a church and in a conference room of a birthing facility. Both sites had a giant room where chairs were set up in two circles. The first circle was the largest with about thirty chairs and was closest to the entrance. This was where the mothers and at least one leader sat and where the primary larger discussion took place. Topics included the importance of breastfeeding, how to breastfeed an older child and an infant (called tandem feeding), benefits to mother and to infant, and other general topics. The second circle was set up away from the entrance in a much smaller circle, often with eight chairs or fewer. This group also was lead by a second Trained Volunteer leader, but it was used to troubleshoot problems mothers were having rather than to discuss topics in general.

Mothers brought the infant they breastfed to the meetings, and in some cases older children as well. The morning meeting was open to mothers and children, while the evening meeting was also open to fathers and spouses. Women openly breastfed at both meetings, usually without cover ups or anything to obstruct their view of the baby as he or she nursed. Mothers were encouraged to breastfeed both infants and older children, who frequently walked up to mothers and latched themselves on whenever they wanted milk. I counted 25-35 mothers at every meeting. Of the thirty mothers on average in attendance, between 20 and 25 mothers were White and the others appeared Hispanic. There was one Asian mother present at both evening meetings.
I introduced myself as a mother who had breastfed two children and who was now a student studying the factors that influence whether or not a mother breastfeeds. I sat quietly through the meetings, taking notes with their permission and listening.

I attended four meetings total, two morning meetings and two evening meetings. I planned to attend more, but I spoke with two Trained Volunteer leaders about the attendance of Black mothers. “We don’t have any African American mothers who attend regularly,” the leader who facilitated the morning meetings told me. She was a White woman whose young children were in attendance as well. “Sometimes one will come to a meeting but usually not return. We have no idea why. These meetings are open to everyone who breastfeeds and wants support.” A second Trained Volunteer, an RN with thirty years of experience as a nurse and lactation expert, voiced a different opinion. She told me that the organization’s “structure as it is set up is kind of racist.” The younger leader who facilitated the meeting seemed surprised at this statement but did not disagree. The second leader went on to say, “There are no Black women in leadership, the meetings are not in Black neighborhoods, and the timing just recently switched to add evening meetings because Black mothers work during the day. How can we expect them to participate and get the support they need when we don’t make ourselves accessible?” I attended three more meetings after this first meeting, but when I did not see any Black mothers I decided not to return.

Breastfeeding Clinic

A second type of meeting took place just a few miles north of these support group meetings. Unlike the general support and mother-to-mother counsel offered at the first set of meetings, this meeting was a breastfeeding clinic set up to provide clinical advice. The group met on the second Tuesday of each month. The chairs were set up with a small waiting area in
the middle of the room next to a changing table and a baby scale for weighing the baby before and after feedings. In two or three corners of the room, there were a couple chairs clustered together behind a portable divider, set up to allow some privacy for the mother. One mother at a time sat in a chair behind the divider, while the other chair was occupied by a licensed registered nurse/IBCLC who was paid to provide clinical advice and to diagnose medical and physical reasons that might prevent a baby from nursing properly or create pain for the mother.

Because these meetings were not set up for general support, there was no open discussion the four times I attended. A table was set up by the door to check a mother into the clinic and assess the reason for her visit before she was told to have a seat and wait for a lactation counselor to become available. The experts wore latex gloves and used antibacterial solution between visits to ensure no transfer of germs from one family to the next. Unlike the Trained Volunteers at the breastfeeding support group meetings, these professionals were paid experts who completed paperwork and maintained files of the women they assisted.

I counted a total of twenty-five mothers between the four meetings I attended: twelve appeared to be White, four were Hispanic, two were Asian, and three were Black. Four women had brown skin but it was difficult to determine their heritage based on their names and how they looked.

One of the Black mothers had breastfed older children and wanted some assistance with adjusting the baby’s latch. A second mother was in pretty serious pain and wanted to know whether she was nursing improperly or had developed an infection. The third mother was concerned that her baby was not getting enough breast milk, so she was instructed to weigh the baby, nurse and then weigh him again. I did not actually see one of these mothers breastfeed. The third mother who was instructed to nurse the baby went to a private corner of the room and
sat behind a partition. This was unlike the other mothers, who freely exposed their breasts and fed their babies in plain sight in the waiting area. I did get the sense that all the mothers, including the Black mothers, were grateful for the clinical help offered freely by these experts.

**Breastfeeding Meet Ups for Black Mothers**

I became connected with an organization local to the Tampa Bay area whose stated mission “by increasing access to prenatal, perinatal, and breastfeeding education and peer support” is “dedicated to normalizing breastfeeding by supporting, promoting and protecting the rights of all women who choose to breastfeed.” What is unique about this organization is its target audience is identified as brown skinned mothers and babies. The leadership is African American women, all mothers, and they host monthly meetings in Brandon and St. Petersburg to provide support, education, troubleshoot infant care strategies, and provide opportunities for mothers and their older children to socialize in an environment where breastfeeding is normalized.

I have attended six support group meetings and become a regular member. The meetings take place in public spaces, by design both for their accessibility and to make the statement that Black mothers should comfortably be able to breastfeed their children anyplace that mothers and infants frequent. Brandon meetings take place in a family multipurpose room at a large shopping mall. There was an L-shaped sofa, table and chairs in the main room in front of a television. Attached to this room is a space with hand dryers, paper towels and five sinks, each of which is equipped with a changing table. Down a short hallway there are three hidden spaces with a recliner chair and a curtain that closes to allow for privacy, and the hallway ends with a large bathroom with a toilet and sink for an adult and a second toilet and sink for a small child.
Due to the proximity of this space to the food court, these meetings are very visible to passersby. The mothers who attend these meetings are not unnerved and are seemingly unaware of onlookers and passersby. Because the space is open to families, men frequently come with their children and often use the changing tables which are visible from the main seating area. I never saw anyone stare at the mothers, nor turn away with disgust. Breastfeeding publicly appears to be an everyday occurrence, normal both to the mothers who breastfed and to others who saw them.

I counted between five and ten mothers at each meeting. Some mothers attended every meeting and others only attended one of the six meetings I attended. At the first meeting, I introduced myself as a mother who had breastfed who was now studying how African American mothers choose to feed their children. “That’s easy,” I was told immediately by one mother. “They get advice that breastfeeding can’t be done if they work so they don’t even bother.”

“It’s not that simple,” a second mother countered. “I knew I was going to breastfeed because that’s what the women in my family do. Some women have never seen anybody breastfeed.”

“I never saw anybody breastfeed in my family either,” a third mother stated. “But I made the decision to breastfeed because I knew it was the best for my baby and me.”

“Exactly,” the second mother commented again. “If you don’t know that breast is best, then it will never be worth going to all the trouble.” The mothers seemed to agree this was true.

From there, the conversation strayed to topics that the literature says Black mothers do not usually discuss or do. The mothers talked about wet nursing, which is breastfeeding another person’s child. One mother told us, “I breastfeed any kids that come to my house. I’m too lazy to make them a bottle [of formula], so if they come to my house they get a boob. Their mamas
know and just have to deal.” She was not being sneaky about this. Instead, this mother had a solution to feeding that seemed acceptable to herself and, I imagine, also to the baby’s mother.

When the subject of donor milk came up, the mothers argued that offering money in exchange for breast milk from African American mothers was at least a change of pace from other ways that African American communities have been exploited for free. One of the group’s leaders, a health educator, told the others that donor milk was even being used more in hospitals. “Preemies who are 32 weeks and younger get donor milk through the hospital,” she told the others. “Otherwise you can arrange it with a friend if you need more milk.” In addition to sharing information, this meeting was also a network of shared support.

It is hard to say what exactly was different about these meetings that invited Black mothers into the groups. The first two types of groups were equally as welcoming of Black mothers. However, the mere presence of Black mothers at the helm of these meet ups seemed to create a feeling tone that invited other Black mothers in. Nevertheless, all of the meet ups I attended with this group were similar. The mothers discussed positive parenting strategies, co-sleeping, tandem nursing, and healthy eating for breastfeeding mothers. More importantly, the women were fearless in silent activism, expressing their value of public breastfeeding and asserting their rights to parent in the ways they believed to be best. And all the while, they sat together in a circle and breastfed their children in public, in solidarity with friends who laughed and offered support, and---from what I could observe---in complete comfort.

CONCLUSION

I witnessed many mothers feeding and interacting with infants throughout the various types of settings, both public and semi-private. From playing with their children in parks or at education facilities to attending support group meetings, the mothers I observed went to special
efforts to provide the best nutrition and care for their children that they could. While non-Black mothers who breastfed their infants appeared to be comfortable enough feeding in public, Black mothers were more cautious about their settings. Black breastfeeding mothers did not always breastfeed their children in public locations where other mothers felt comfortable doing so. Even when surrounded by other breastfeeding mothers, Black mothers who breastfed in public settings did not feed around others in great quantities. And those who did breastfeed in public appeared to want to hide themselves from sight.

The exception to this was the breastfeeding support group for Black mothers. In this unique setting, Black mothers breastfed their infants surrounded by other mothers and also in front of passersby who frequented the space. Surrounded by Black mothers who breastfed and under the guidance of Black mothers, they sat and chatted and breastfed without regard from the strangers—men and women alike—who passed by and saw them. How comfortably they breastfed in this setting was in stark contrast to how shielded Black mothers were in other settings.

Breastfeeding in public is not a behavior in which all mothers partake. While messages abound about the benefits of breastfeeding for mothers and infants, breastfeeding in public and even in semi-private settings is not as common a practice in the US as it is in other countries (Van Esterik 2002). As the terrain shifts to make breastfeeding an acceptable practice for the mothers who choose to breastfeed, however, it appears that there is a special role for Black mothers to model breastfeeding for other Black mothers. In this capacity, they serve as educators and also provide living examples to consider breastfeeding a part of being a good mother in which they should be proud.
CHAPTER FIVE: PHASE II AND III FINDINGS – AFRICAN AMERICAN EXPERIENCES OF GOOD MOTHERHOOD

Chapter Five presents the findings from phases II and III of the study. Between February and October 2017, I interviewed African American mothers and the professionals who work with them during their child’s infancy. The purpose of the interviews was to learn from African American mothers how they experience and value the tenants of motherhood, and to compare what they value for themselves and their families to what health professionals value for African American families. Each phase is presented briefly below with an overview of the participants of each research phase, and then the data is merged to present the thematic findings across both groups. Presenting the findings thematically allows for insights to be understood across both health professionals and mothers, both to identify commonalities among these perspectives and differences between them.

HEALTH PROFESSIONALS: AN ETIC PERSPECTIVE

Following my participant observations of mothers in public spaces and the various meetings I attended, I began the second phase of my research. The intention of this work was to meet with my key informants, health professionals who provide specialized support to mothers at the end of their pregnancies or immediately following a baby’s birth. My hope was that they could provide an etic perspective as outsiders who work so closely with mothers and infants of what African American mothers experience in early motherhood, what they appear to value for their families and what the professionals feel African American mothers should value.
KEY INFORMANTS’ DESCRIPTION

For the second phase of research, I interviewed fifteen key informants. These informants were invited to participate in this research because they worked—either as paid or unpaid—in a capacity that supported, educated or encouraged African American mothers during the end of pregnancy or during the early infancy period. In this capacity, these informants help mothers maintain health during pregnancy, teach them about childbirth and early infant care, including breastfeeding and wet nurse options, formula options, diapering, co-sleeping and more. The subjects identified their professional work with mothers using the titles and descriptions below. Three of the fifteen key informants (20%) worked for organizations outside of the state of Florida with successful strategies for educating and supporting African American mothers to breastfeed their infants. The other key informants work with organizations in support of mothers in Tampa Bay.

TABLE 5.1 KEY INFORMANT TITLES

<table>
<thead>
<tr>
<th>Key Informant Titles (N=15)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse/Certified Lactation Consultant or Counselor (CLC)*</td>
<td>4 (two of whom worked for an out of state organization that specialized in breastfeeding)</td>
</tr>
<tr>
<td>Nurse/CLC/Researcher</td>
<td>1</td>
</tr>
<tr>
<td>Health Educator/CLC</td>
<td>2</td>
</tr>
<tr>
<td>CLC only</td>
<td>1</td>
</tr>
<tr>
<td>OBGYN/Researcher</td>
<td>1</td>
</tr>
<tr>
<td>Midwife only</td>
<td>2</td>
</tr>
<tr>
<td>Postpartum Doula only</td>
<td>1</td>
</tr>
<tr>
<td>Health Educator only</td>
<td>1</td>
</tr>
<tr>
<td>Trained Volunteer only</td>
<td>2 (one of whom worked for an out of state organization that specialized in breastfeeding)</td>
</tr>
</tbody>
</table>

*CLCs noted above are one of two types of certified lactation experts: 1) International Board Certified Lactation Consultant (also titled IBCLC) is a national certification that can be earned by health professionals and those with clinical expertise in human lactation; and 2) Certified Lactation Counselor (CLC) is also a national certification but one that does not require clinical training or experience. Often registered nurses, midwives and other medical professionals study to become IBCLCs whereas those without a clinical background can more readily access the CLC certification. See https://iblce.org/ and https://www.alpp.org/certifications/certifications-clc.

CLIENT BASE

All key informants said they have worked with mothers from various racial, ethnic, religious, socioeconomic and age groups. Six of the fifteen key informants specified that their
clients and customers at present were mostly African American women. Among those experts who worked primarily with African American women, two specified that they worked with young African American mothers, many of whom were under the age of 18 years. Twelve of the fifteen key informants worked with women in Tampa Bay. The remaining three worked with organizations outside of Florida that have success in supporting and encouraging African American mothers to breastfeed their infants. Additional findings from interviews with key informants are presented by theme in the next section in combination with findings from African American mothers.

**MIDDLE CLASS AFRICAN AMERICAN MOTHERS: AN EMIC PERSPECTIVE**

The third phase of research centered on obtaining insights from African American mothers, and understanding what factors in their experiences influenced their decisions of how to feed and care for their infants. The section below includes a description of the mothers, how their families and households were structured, their jobs and financial situations, and details about the infant’s birth and early care.

**MOTHERS’ DESCRIPTIONS**

I interviewed forty-three middle class African American mothers for this research. The first criteria for inclusion in this study, besides being 18 years of age or older and a mother, was identifying as a “Black” or “African American” person who was born in the United States. All of my participants met this criterion and reported that (to their knowledge) their parents and grandparents were also born in the US. This identity as an “African American” was critical for establishing a similar cultural heritage and history among study participants and to eliminate possible variation in childhood rearing practices from cultures outside of the US. Interestingly, fourteen of the forty-three mothers were married to men from different racial or ethnic
backgrounds, men who did not identify as “Black” or “African American.” Eleven of the fourteen were mothers who breastfed their children.

Of the forty-three mothers I interviewed, twenty-three mothers breastfed their children (MBF) during the newborn stage, or during the first thirty days of the infant’s life. Twenty of the mothers interviewed formula-fed their children (MFF). Some of the mothers had more than one child. To ensure the freshest memory of feeding and caretaking for their child, the mothers were asked to report information on the child born most recently, all of whom were five years of age or younger at the time of the interview.

**MCAM Histories and Descriptive Details**

I collected demographic information from the mothers and some of their life histories about the time in their lives when their babies were born. This information helps to contextualize their lives at the time, and offers some insights into the financial and social influences in their lives that may have contributed to decisions about how to feed and care for their infants.

**Other (Older) Children**

<table>
<thead>
<tr>
<th></th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(21.7%)</td>
<td>(15.0%)</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(34.8%)</td>
<td>(30.0%)</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>(26.1%)</td>
<td>(45.0%)</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(13.1%)</td>
<td>(5.0%)</td>
</tr>
<tr>
<td>4+</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(4.3%)</td>
<td>(5.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>
Most of the mothers in this study had older children prior to the youngest child (who as the subject of this study was either breastfed or formula fed and was born within the last five years prior to this study). Eight mothers had no children prior to the youngest child: five were MBF (21.7%) and three were MFF (15%). Among those MBF with older children, eight mothers (34.8%) had one other children, six mothers (26.1%) had two older children, three mothers (13.1%) had three older children and one mother (4.3%) had four. Among MFF, six mothers (30%) had one other child and nine (45%) had two older children. Additionally, one mother had three older children and one MFF had four (5% respectively).

*Other Household Occupants (When Baby was Born)*

Among all forty-three mothers from the study, none lived alone with just her baby. All of the mothers shared their residence with others at the time her youngest baby was born. However, MBF were more likely to live with their spouses and children rather than with extended family members. Five mothers among MBF (21.7%) lived with a spouse or partner and the baby, while another thirteen (60.9%) lived with a spouse/partner and multiple children. Only three MBF (13%) lived with a spouse, children and a parent. One MBF (4.3%) lived with her children and a parent and did not have a spouse.

<table>
<thead>
<tr>
<th>Table 5.3 Other Household Members</th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived alone with baby</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lived with spouse + baby</td>
<td>5 (21.7%)</td>
<td>3</td>
</tr>
<tr>
<td>Lived with spouse + children</td>
<td>14 (60.9%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Lived with spouse + children + parent</td>
<td>3 (13%)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Lived with children + parent (no spouse)</td>
<td>1 (4.3%)</td>
<td>5 (25%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>
Fewer MFF lived with a spouse and her child (n=3, 15%) or children (n=4, 20%). Eight MFF (40%) lived with a spouse, children and a parent. However, five MFF (25%) lived with a parent and did not have a spouse. Thus, mothers who fed their children formula were more likely to live with a parent than mothers who breastfed their children.

*Mother’s Age*

Of the twenty-three MBF, three (13%) were ages 18-24 years and five (21.7%) were ages 35-44 when their youngest child was born. 65%, the largest group of MBF (n=15), were ages 25-34. Of the twenty MFF, the largest group of mothers (n=11, 55%) was the youngest group, ages 18-24. Six MFF (30%) were ages 25-34 and three (15%) were ages 35-44. None of my study participants was 45 years of age or older at the time the youngest child was born. Also, because this study focused on adult women, none of my study participants were under 18 years of age.

The mothers who breastfed their children were, on average, older than the mothers who formula fed their children. This was consistent with the scientific literature on breastfeeding, which denotes that older mothers are more likely to breastfeed their children than younger mothers (CDC 2007).

**Table 5.4 Mother’s Age at Infant Birth**

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>MBF</th>
<th>MFF</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>3 (13%)</td>
<td>11 (55%)</td>
<td>14 (32.5%)</td>
</tr>
<tr>
<td>25-34</td>
<td>15 (65.2%)</td>
<td>6 (30%)</td>
<td>21 (48.8%)</td>
</tr>
<tr>
<td>35-44</td>
<td>5 (21.7%)</td>
<td>3 (15%)</td>
<td>8 (18.6%)</td>
</tr>
<tr>
<td>45+</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
<td>43 (100%)</td>
</tr>
</tbody>
</table>
MATERNAL EDUCATION

This group of mothers was fairly educated. Among MBF, two (8.7%) of twenty-three mothers had a high school diploma only. Seven MBF (30%) had completed some college education while nine (39%) had earned a bachelor of arts or bachelor of science degree. Five of the twenty-three mothers (21.7%) attended graduate school. Three had master’s degrees, one had a Ph.D. and one was a medical doctor.

<table>
<thead>
<tr>
<th>Table 5.5 Maternal Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>High school diploma</td>
</tr>
<tr>
<td>Some college (2 years higher education: AA, RN, licensed professional, etc.)</td>
</tr>
<tr>
<td>Bachelor’s degree (4 years higher education)</td>
</tr>
<tr>
<td>Master’s degree</td>
</tr>
<tr>
<td>PhD/MD/JD/other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Among MFF, two (10%) of the twenty mothers had a high school diploma. Half of the mothers (n=10, 50%) had completed some college and seven (35%) had earned a bachelor of arts or bachelor of science degree. One MFF (5%) had a master of art’s degree at the time her youngest child was born.

JOB TITLE (WHEN BABY WAS BORN)

The mothers I interviewed worked in several careers. The majority of MBF (7 of 23, or 30%) worked in health related careers and reported working as health educators, nurses, dieticians, and one was a medical doctor. Four MBF (17%) had administrative jobs and worked in professional offices. Three MBF (13%) worked in public education, one as a professor and
two as school teachers in public schools. Two MBF (8.7%) worked as cosmetologists and another two worked in customer service. One MBF (4%) worked in retail sales. Of the MBF, four (17%) were full-time mothers at the time the baby was born. They were unemployed, but because none of them was seeking employment at the time and identified as working at home, they are categorized as full-time mothers/unpaid rather than unemployed.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator (professor, school teacher, etc.)</td>
<td>3 (13%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Health field (RN, MD, Health Educator, Dietician, etc.)</td>
<td>7 (30.4%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Administrator (Admin assistant, receptionist, desk job)</td>
<td>4 (17.4%)</td>
<td>7 (35%)</td>
</tr>
<tr>
<td>Cosmetologist (hair, make-up, skin professional, etc.)</td>
<td>2 (8.7%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Retail/sales</td>
<td>1 (4.5%)</td>
<td>-</td>
</tr>
<tr>
<td>Customer service</td>
<td>2 (8.7%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Full-time mother/unemployed</td>
<td>4 (17.4%)</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

In contrast, MFF were most likely to work in administrative positions in professional offices (7 of 20, or 35%). Equal numbers of MFF worked in education and as cosmetologists (4 of 20, or 20% each) and three (15%) worked in customer service. Interestingly, only two MFF (10%) worked in health related positions during their pregnancies.

**JOB’S RESPONSE TO PREGNANCY (WHEN BABY WAS BORN)**

When asked about their employer’s responsiveness to their pregnancies, the majority of the mothers felt that their pregnancies were well received. Among MBF, the majority (n=17 or 73.9%) felt their employer was supportive. They were offered a maternity package which
included either paid or unpaid leave with an opportunity to return to their jobs. Two MBF (8.7%) did not feel their jobs supported their pregnancies. One of these mothers has a demanding job as a medical doctor and felt that there was pressure to maintain excessive (more than 40 hours per week) work hours. She did maintain this level of commitment prior to pregnancy, but her job was not able to reduce her workload to her satisfaction. After her maternity leave, she reduced her hours from full time to part time and was again satisfied with her job. A second mother felt that her job was disappointed with her pregnancy because her position required her to be available during the holidays and her baby was due in December. Neither mother felt worried that her job was threatened due to having a baby. In addition, four MBF (17.4%) were unemployed when the baby was born.

All mothers who formula fed their babies were employed when their babies were born. Of the MFF, 75% (n=15) felt their employers were supportive (and in some cases, enthusiastic). Among both MBF and MFF who felt supported, mothers told me their employers or coworkers threw them parties or bought them gifts to celebrate to coming baby. However, 25% of MFF felt their jobs were unsupportive. One mother said “I felt like they were saying, ‘the new baby better not get in the way of you doing your job or we can replace you’.” Others felt they worked in a competitive environment and that having a baby could slow the potential to progress in their career. The mothers felt some pressure despite the happiness of their pregnancies to demonstrate that their work was important to them because they were pregnant. One mother felt unsupported because her job was unable to provide financial compensation during her leave, a fact which she was aware of at the time she accepted the position but which she was still disappointed they could not reverse when her circumstance could benefit from it. However, none of the mothers
who felt unsupported were worried that they would be fired or lose their jobs. Rather, a few worried about losing their edge when they had worked so hard to obtain their positions.

**TABLE 5.7 Job’s Response to Pregnancy**

<table>
<thead>
<tr>
<th></th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive/supportive</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>(73.9%)</td>
<td></td>
<td>(75%)</td>
</tr>
<tr>
<td>Negative/not supportive</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>(8.7%)</td>
<td></td>
<td>(25%)</td>
</tr>
<tr>
<td>Fired/lost job</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Not applicable/unemployed</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>(17.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

**Work Status/Career (Pre-Birth and After Birth)**

Mothers were asked about the status of their work and careers at the time of the youngest child’s birth. Among MBF, the four mothers who were not working were financially supported by a spouse (n=3, 13%) or parents (n=1, 4.3%). Of the nineteen MBF who were employed at the time of the child’s birth, twelve (52.2%) worked a full-time job and seven (30.4%) worked a part-time job. All MBF with full-time positions were granted at least six weeks of paid maternity leave. Six MBFs (26.1%) with part-time jobs were also granted unpaid leave with the option to return to work after the first six weeks. Only one MBF had a job that did not offer unpaid leave or an option to return to guaranteed employment after maternity leave, but she was aware of this option and planned to stay home with her baby.

Interesting to note is the changes to employment that occurred for the mothers once their children were born. Among MBF who were employed either full-time or part-time at the end of their pregnancies, three (13%) left their jobs to stay home with their children and were financially supported by their spouses. Two mothers left full-time jobs (8.7%) and one left a
part-time job (4.3%). The mothers commented that during the early months after the baby was born, “I fell in love with my baby” and “could not stand to work a job where I made just enough to cover the cost of daycare for my baby.” Five MBF (21.7%) with full-time jobs continued to work after maternity leave, but they made changes to their work to accommodate motherhood. Three (13%) changed from full-time work to part-time work and two started home-based businesses of their own. The remaining five MBF (21.7%) who retained their full-time jobs commented that they often adjusted their work schedules or sometimes “went days without sleeping” to accommodate breastfeeding the baby when they were at home. 82.6% of MBF who worked prior to the baby’s birth and 18.4% were full time mothers or unemployed. After birth, less than 70% worked and 30% were full-time mothers.

By contrast, none of the MFF were unemployed at the time of the child’s birth. Among the twenty MFF who were working, twelve (60%) worked full-time and eight (40%) worked part-time. The ability to work and return to work was an important tenant for all employed mothers, but this concept was most prevalent among mothers who depended upon their jobs for income.

<table>
<thead>
<tr>
<th>Table 5.8 Work Status/Career Pre-Birth and After Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBF</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Full-time mother/unpaid/supported by spouse</td>
</tr>
<tr>
<td>Full-time mother/unpaid/supported by parents</td>
</tr>
<tr>
<td>Worked full-time</td>
</tr>
<tr>
<td>Worked part-time</td>
</tr>
<tr>
<td>Self employed/home based work</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
After their babies were born, MFF also made changes to their work status but the changes were less significant. Two (10%) of the mothers who were working full-time switched to part-time work, but one mother found that she needed the added income and switched from part-time work to full-time work shortly after her baby was born. Two mothers (10%), one who worked full-time and one who worked part-time before their babies were born, stopped working altogether. None of the MFF became self-employed or worked from home after the baby was born. Thus, 100% of MFF worked pre-birth and this decreased to 90% after birth: 10 (50%) full time and 8 (40%) part time.

*Place of Delivery*

Mothers in this study delivered their babies in a variety of settings. The majority of both MBF and MFF mothers---65% and 75% respectively---gave birth to their children in major hospitals. The delivery was under the care of a licensed medical professional who was either a medical doctor or a nurse midwife. Planned homebirths were the second largest alternative birth setting.

<table>
<thead>
<tr>
<th></th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>15  (65%)</td>
<td>15  (75%)</td>
</tr>
<tr>
<td><strong>Birthing Center</strong></td>
<td>1   (4.3%)</td>
<td>2   (10%)</td>
</tr>
<tr>
<td><strong>Planned homebirth</strong></td>
<td>5   (21.7%)</td>
<td>3   (15%)</td>
</tr>
<tr>
<td><strong>Unexpected/emergency setting (home, ambulance, car, etc.)</strong></td>
<td>2   (8.7%)</td>
<td>1   (5%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

Five of the MBF births (21.7%) took place at home under the direction of a licensed midwife, with another one (4.3%) taking place as planned with a licensed midwife at a birthing center. Two MBF births (8.7%) occurred in unexpected, emergency settings. One mother
delivered her baby in an ambulance after getting into a minor car accident on the way to the hospital. A second mother delivered her baby in the car at the hospital, where she and her husband arrived without enough time for the mother and baby to be taken to the delivery unit. All births were assisted and babies were born healthy.

Besides the babies delivered at the hospital, three MFF (15%) gave birth to babies born at home through planned home births under the care of licensed midwives. Two MFF births (10%) took place at birthing centers, also under the care of a licensed midwife. One MFF birth (5%) took place unexpectedly at home and was an unassisted birth. She and her husband planned to stay home to labor as long as they could and were surprised that the mother’s labor progressed as quickly as it did. Mother and baby were fine, and an ambulance arrived within minutes of the birth to assist with the after birth and to transport them to the hospital. All but one birth was assisted, but all of the babies were born healthy.

**INFANT FEEDING**

*SIDE NOTE: DEFINITIONS OF BREASTFEEDING*

One important thing I learned from my research was that there is variation across the board in the definitions of “breastfeeding.” I was aware that this discrepancy existed in the literature and decided for the purposes of this study to define breastfeeding by the source of nutrition (milk or formula) rather than by any other physical or emotive factors. However, these very factors were quite relevant to the research participants.

Mothers, both MBF and MFF, generally defined breastfeeding as latching a baby onto the mother’s breast and feeding the infant breast milk. In the instances in which a mother who breastfed (MBF) could not latch her baby onto the breast to feed, she sometimes pumped milk to allow a caretaker to feed the baby a bottle of breast milk in her absence. Likewise, mothers who
formula fed (MFF) seemed to distinguish formula feeding from breastfeeding by the source of nutrition: breast milk or infant formula. This definition emphasizes the type of food provided to the infant but it makes no claims on whether the baby obtains this food by being latched onto the mother’s breast or being fed from a bottle.

However, the lactation experts used distinctly different definitions to define breastfeeding. A key informant---a nurse/IBCLC---defined breastfeeding as the act of a mother holding the baby to her breast while feeding breast milk. One example of this is transferring milk from the breast to a baby. A second example she used is called a supplemental nursing system (SNS), which enables a mother to latch her baby onto her breast and feed the baby either pumped breast milk or formula that is then taped onto mother’s breast so the baby can be fed while being latched onto the mother’s breast. This definition emphasizes the act of feeding the baby rather than the type of milk, claiming that the act of nursing provides the greatest benefit to baby. With this example, a mother could engage in the act of breastfeeding without necessarily feeding her baby breast milk.

Another key informant---a Health Educator/CLC---told me that “breastfeeding is the act of feeding mother’s milk directly to a child from the mother’s breast.” When I asked whether a baby receiving breast milk in a bottle was synonymous with breastfeeding, she told me “that is a common mistake people make” and that “any feeding from a bottle is actually considered to be supplementing, even if you supplement with breast milk.” According to this definition used by some lactation experts, many mothers who consider themselves to exclusively breastfeed their children may fall short of the optimal act if they pump and offer a bottle of their milk.

I thought these distinctions were worth noting, given that the informants had definitions that varied from one another and from the mothers with whom I spoke during my interviews.
Because the leading breastfeeding policy makers currently define breastfeeding by their focus on
the benefits of breast milk for the baby (WHO 2002; UNICEF 2018; Labbock 2000), the term
“breastfeed” in the analyses below refers to providing breast milk to an infant. MBF in this
study usually breastfed by latching an infant onto her breast to feed. However, babies who
received breast milk in a bottle were still considered to be breastfed for the purposes of this
study.

INFANT FEEDING DURING THE FIRST 30 DAYS

For the purposes of this research, the study population was limited to mothers who
identified as feeding their babies either “exclusive breast milk” or “exclusive artificial milk.” All
twenty-three MBF met the definition of exclusive breastfeeding mothers, which I defined as
mothers who fed their babies breast milk during the first thirty days with no exposure to formula
(“artificial milk”), water, juice, or other foods or liquids. All of these mothers reportedly latched
their babies onto their breasts and nursed directly at some point during the first thirty days after
the baby was born. Five MBF (21.7%) also used a breast pump during the first thirty days to
obtain milk so the baby could be bottle fed by a spouse, parent or other caretaker.

Additionally, two mothers (8.7%) said their babies were fed breast milk by a friend who
was also nursing her own baby. This practice, called wet nursing or milk sharing, came up
casually in the interviews as though it was a common practice. When asked why the friend
nursed the baby, one mother said “she was watching both babies while I went to the doctor and it
was easier to let her feed [my son].” The other mother said, “all breast milk is the same as long
as the mother is healthy and doesn’t smoke or drink.”
### TABLE 5.10 INFANT FEEDING

<table>
<thead>
<tr>
<th></th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breast milk (mother/wet nurse/donor)</td>
<td>23</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td></td>
</tr>
<tr>
<td>Exclusive artificial milk (formula only)</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(100%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

Mothers who fed their babies formula (“artificial milk”) did not all begin by feeding their babies formula. Six MFF (30%) were open to the idea of breastfeeding their babies, but this changed once the baby was born. One mother told me, “It is just hard to do, and all the books I read that tell you how good breastfeeding is for the baby never told me that part.” Another mother said, “the nurse tried to encourage me to breastfeed, but when I latched her on, I didn’t seem to have to make enough milk and I was worried she was not getting fed.” A third mother said, “I was exhausted after giving birth. I needed to sleep, so I let [my spouse] feed the baby so I could sleep and we kept that routine for the first two weeks while we were home.” I asked this mother if she considered trying to breastfeed once she had gotten some rest, and she said “why would I bother? The baby was gaining weight and sleeping within a few weeks. There was no need to stop doing what worked.”

Interestingly, a number of mothers changed their decision about how to feed the newest child in comparison to how they fed their older children. Among MBF, twelve (52%) previously breastfed their children while eight (35%) fed their child(ren) formula. Three (13%) MBF used a combination of both breast milk and formula. Some of the reasons MBF offered for switching away from formula to breastfeeding with the youngest child included knowing the benefits of breastfeeding now that they did not know with previous pregnancies; being as one mother described “older and wiser”; and having more stability in their job or more stable finances than they had previously which allowed greater flexibility to be able to breastfeed.
The shift for MFF was less significant. Among MFF, eleven (55%) previously fed their children formula and six (30%) used both breast milk and formula. However, three MFF (15%) previously breastfed their children. When asked why they switched from breastfeeding to formula with this latest baby, the mothers all said they had less time available between work and caring for other children and that, as one more put it, “breastfeeding is more work and I did not have it in me to do any more.”

**Table 5.11 Feeding of Older Children**

<table>
<thead>
<tr>
<th>Feeding Method</th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breast milk (mother/wet nurse/donor)</td>
<td>12 (52.2%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Both breast milk and artificial milk</td>
<td>3 (13%)</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>Exclusive artificial milk (formula only)</td>
<td>8 (34.8%)</td>
<td>11 (55%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

**Baby’s Primary Caretaker During First 30 Days**

During the first thirty days after birth, the mother was the baby’s primary caretaker in most cases. For many mothers this changed after the first month in order to enable mothers to return to work and begin to handle other obligations that had been put aside during their newborn’s first month of life.

Among MBF, twenty mothers (87%) were the primary caretaker for their newborn baby during the first thirty days. The primary caretaker was defined as being the person to care for the baby 75% of the time or more. One mother described it in a way that seemed to reflect the sentiment of other mothers who were the primary caretaker: “For that first month, my [spouse] and family cycled in and out to help change diapers or hold him, but I did the feeding, the burping, and was home with him while I recovered from childbirth.” Only three mothers (13%) described their newborn’s caretaking as being a shared effort, with 50% of the baby’s care being
shared with others. Two shared with a spouse and one shared with a parent. When I asked mothers to describe how sharing infant care looked, I was told: “I was the food source, but I got as much help with changing diapers, burping, rocking and holding [baby] as I could get. I wasn’t trying to raise this baby by myself.” Another mother said: “After giving birth, I barely had the energy to feed her, let alone to take care of her by myself. The other duties are what dads and grandparents are for.”

The situation was very different for MFF. Ten of the twenty MFF (50%) identified as being the primary caretaker for their newborn baby. Nine MFF (45%) said they shared that responsibility equally with either a spouse or parent, and later (after the first month) with a daycare provider. One mother said, “[my spouse] made bottles and handled the feedings, my mother did all the cooking and I did the rest. It took a village to care for the new baby and my other kids.”

### Table 5.12 Primary Caretaker

<table>
<thead>
<tr>
<th>Primary Caretaker</th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother (75% of the time)</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Spouse (75% of the time)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Grandparent (75% of the time)</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Other relative (75% of the time)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Daycare provider (75% of the time)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Shared caretaking (50% mother, 50% spouse/parent/daycare provider)</td>
<td>3 (13%)</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

The ability to share infant feeding with a spouse or parent may have made it easier for MFF mothers to share caretaking, and also allowed for a balance resting to occur. In one instance (5%), an MFF said her mother was the primary caretaker for her newborn. The mother described that it was easier to let her mother take primary care of her newborn than to ask her mother to help with her older children’s care. She explained: “I could take my other kids to
school, make meals and care for them because my mother could devote her time to that one baby. It made those first few weeks easier and also allowed me to get caught up on my sleep.”

**HOW AFRICAN AMERICAN MOTHERS WERE FED AS INFANTS**

Mothers were asked how they were fed during their infancy, although some volunteered this information before they could be asked. Thirteen MBF (56.6%) reported being breastfed for at least a portion of their infancy compared with six MFF (30%). Five MBF (21.7%) reported being fed formula as babies, which is identical to the number reported by MFF (n=5 or 25%). Five MBF (21.7%) reported being both breastfed and formula fed compared with three MFF (15%). In addition, six MFF (30%) were unsure how they were fed.

<table>
<thead>
<tr>
<th></th>
<th>MBF</th>
<th>MFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfed</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(56.6%)</td>
<td>(30%)</td>
</tr>
<tr>
<td>Formula-fed</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>(21.7%)</td>
<td>(25%)</td>
</tr>
<tr>
<td>Both</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(21.7%)</td>
<td>(15%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(30%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

This information provides valuable information about African American mothers. MBF were more likely to be breastfed than MFF and were also more likely to know how they were fed as infants. The reasons for the feeding decisions made during their childhoods, while speculated by the mothers, cannot be known for sure without speaking to their mothers and understanding the context in which decisions made. However, it seems clear that mothers who breastfed were more likely to be breastfed and to have learned about their feeding history than mothers who fed their children formula, which may be due to prioritizing breastfeeding for their own children.
PHASE II AND PHASE III RESEARCH FINDINGS BY THEME

Below are the research findings from phase II, which was interviews with key informants (N=15), and phase III, which was interviews with middle class African American mothers (N=43). The data is categorized into four larger topic areas and are organized such that they follow the research questions and hypotheses that were proposed. There were such similarities between the findings between key informants and MCAMs that it was most logical to present the findings by themes rather than separating them by phases. The similarities amongst the themes between the two group, however, provided a nice confirmation of the information obtained.

INFANT FEEDING VALUES (IFV)

The first objective was to identify what MCAMs value during their baby’s early infancy, and to determine how breastfeeding is prioritized in comparison with formula feeding and other values they hold. I hypothesized that African American mothers define and value the tenants of “good motherhood” differently than non-African American mothers. Part of this definition includes regarding breastfeeding and the benefits attributed to breast milk as less valuable in comparison with other values they hold, such as the opinions of those close to them (the baby’s father, close relatives and friends), their baby’s perceived satiety and health, the ability to share feeding and child care with others, which they believe is easier to do with formula than by breastfeeding, and fulfilling their definition of what it means to be a “good mother.”

Value 1: Good mothers value raising and providing for independent children

The African American mothers I interviewed valued being “good mothers” and felt strongly that being a good mother centers on providing for their families. They also defined a good mother as one who raises independent children, children who are less dependent upon the mother and either able to rely upon others or upon themselves. All of the mothers I interviewed
expressed high hopes for their children’s future successes in areas such as their careers, their relationships, their health and as they progress through their lives. Good mothers, they explained, are expected to make sacrifices to this end, if needed.

When asked “what makes a good mother?”, similar descriptive words were used by both sets of mothers. The words used most often were hard-working, strong, providing and sacrificing for their families. One MBF said: “I try to be a good mother like my mother was. Good mothers are willing to do what it takes to love and care for the family.” Another MBF said: “A good mother has to be stronger than she thinks she can be so she can do what she has to do, even if she is tired or doesn’t feel like it.” This mother later added: “It’s about the willingness to sacrifice for your child. Even if you are uncomfortable or struggle for money, you try to provide so your child never feels that struggle.” Mothers who breastfed described being a good mother as one who sacrifices her time, her energy in place of resting, and in some cases her income (due to either reduced work hours or not working altogether) in order to breastfeed.

A breastfeeding mother provides milk for her child and makes physical and, in some cases, fiscal sacrifices in order to breastfeed. As one MBF stated: “My husband wasn’t too happy at first that I left my job, but he understood that it was what we had to do as good parents to raise our boy.” This MBF believed that working less would allow her to breastfeed and otherwise be more available to her infant, and the sacrifice was necessary to fulfill her definition of a “good parent.” Some of the MBF acknowledged that breastfeeding resulted in reduced availability to work, reduced hours or some form of reduced income so they could be available to care for the infant. None of the mothers depended upon public assistance at this time, but instead they had relatives on whom they could depend. And most of the mothers continued to work in some capacity and still earned some income.
Mothers who fed their children infant formula had similar definitions of the kind of mothers they wanted to be. One MFF said: “Being a good mother means sometimes making the hard decision because it’s what’s best for the family. You don’t always feel like getting up and going to work, but it’s what you have to [do] to be a good mama.” Another MFF, who reduced her work hours but continued to work as a new mother, said: “I worked less to spend more time with my baby, but I needed my job. Being home was what I might have wanted, but providing for my kids is what made me a good mother.” This complex answer brings together two seemingly incongruent notions of motherhood. She shifted her work schedule because she wanted to spend time with her newborn, but she did not identify this behavior as being an act of a good mother. Rather, she recognized the act of continuing to work so she could provide for her family as fulfilling her definition of being a good mother. Mothers who formula-fed were more likely to indicate that being a good mother required them to work, to provide for their families fiscally and in some cases mothers stated that breastfeeding would have been a competing value that would have detracted from being a good mother. The differences in definitions of “good motherhood” offer insights into how an African American mother could be choose to either breastfeed or formula feed her infant in her effort to do what she believed to be best for her child. MFF considered the sacrifices made by good mothers a little differently. While some mothers never intended to breastfeed, others considered not breastfeeding to be a necessary component of good motherhood. They felt that being a good mother meant sacrificing their time with their infant in order to work and provide for the family. One MFF said: “I knew on one hand that I wanted to raise my baby, but I had responsibilities that I would have missed out on providing if I did not work.” While the mechanism of fulfilling her definition of being a “good
mother” differed from the MBF above who left her job, both mothers had the same stated goal and made decisions to achieve it.

The independence of a child was an important goal for African American mothers, and is also a valued tenant of a good mother. One certified lactation counselor (CLC) stated: “All mothers want children who are adaptable and fine wherever they go, but some feel that breastfeeding creates a dependent child so they won’t do it.” The issue of dependency is problematic when the mother is not available, whether because she is working, taking care of other needs or sleeping. African American mothers were described as having competing values in wanting children who can function independently, especially in cases where mothers shared caretaking duties of their children, and wanting to breastfeed. A health educator explained:

“What’s a ‘titty’ baby? It’s a baby who gets breastfed that is considered to need more attention, more time, to want to suckle all the time, all the things that build attachment. Black mothers feel strongly early on about raising independent babies cause one that needs you 24/7 won’t be content to go to day care or be taken care of by Grandma while Mama works. And that can be a serious problem.”

The concept of “a titty baby” came up in several interviews and was never defined as a desirable child. Building attachment was identified as being the antithesis of a good mother’s goal of raising independent children. MFF in particular voiced concerns that raising an independent child, or a child who was not emotionally attached to its mother, was a valuable goal for a good mother. As a midwife put it:

“Some feel it’s easier to start them with a bottle because then it won’t matter who feeds them later on. If the mother works, then she is spared having to transition
the baby from breastfeeding to the bottle. It can be easier for the mother, and it also causes less guilt for some moms.”

In instances where a mother feels that breastfeeding could compete with independence, she may determine that the best option is to feed a baby from a bottle. Another CLC said that when they know a mother needs to return to work, “We try to encourage them to try breast and bottle at least, but some won’t even bother. It’s a protective mechanism.” The protection here is both for the mother, to avoid guilt, and for the baby to save the difficult of transitioning from breastfeeding to bottle feeding. In both instances, not breastfeeding seems to be the action of a good mother. An OBGYN told me:

“I don’t want to say that Black women don’t take care of their children because they do, but they start teaching independence at an early age. They don’t foster dependence or ‘co-sleep’ or nurse until a child is three. White women do. Black women want children who they think are going to make it out in the world.”

This idea that breastfeeding and closeness would interfere with independence in a child was identified by mothers. A MFF said: “I had seen moms who had these ‘titty babies’ and the babies grew up hanging on them all the time. I needed my children to be independent.” The result of the impression of dependence and a lack of self reliance in another older child translated to this mother as being the reason she could not breastfeed her baby.

One MBF spoke in defiance to this notion of breastfeeding creating dependence with this statement: “I thought if I breastfed my son and he got a lot of attention early on, it would make him more independent later on.” It was her belief that breastfeeding allowed her to foster independence in her son that feeding him formula would not have enabled, an independence that
would be a lasting part of his character. Thus, the importance of creating independence in children was also critical value for all those who wanted to be “good” mothers.

Value 2: Fat, Healthy and Well-Rested Babies

African American mothers value the health and well-being of their babies. Ensuring that a baby is healthy is considered to be another tenant of a “good mother.” This value appears to be held by mothers regardless of whether they fed their babies breast milk or formula. It was identified as an important value by nine of the fifteen key informants interviewed. A nurse/CLC told me:

“Black mothers want big, fat, healthy, happy babies that sleep through the night. This can be a two-edged sword because you worry about setting children up for diabetes by overfeeding them from infancy. But in general, all mothers just want to know that their babies are happy, robust and doing fine.”

Two important issues are addressed in this statement. The first is the importance of having a healthy baby as a universal concept among all mothers, and this connection between happiness, health and “good mothering” is consistent with recent findings (Marshall et al 2007). The second, however, speaks to a culturally held value of some groups which suggests that fat babies a symbol of health (Lampl and Thompson 2007; Ritenbaugh 1991; Thompson Adair and Bentley 2014). One reason that defining healthy Black babies as large babies is concerning is because diabetes and obesity are health concerns that impact Blacks more than other groups in the United States (Chow et al. 2012). Even though recent research has demonstrated that Black mothers are less inclined to hold the belief stated by the CLC above (Thompson Adair and Bentley 2014), the image of a fat baby as a symbol of health and satiety still emerged in multiple interviews. A primary concern for the MCAMs I interviewed was the importance of babies getting enough
milk to be satisfied and grow well to, therefore, be healthy. The notion was echoed by this statement from a midwife: “I don’t think [any mothers] care whether the baby gets breast milk or formula, as long as the baby is healthy, growing well and sleeps.”

This same theme—having a healthy, growing, well-rested baby—emerged in all forty-three interviews I conducted with mothers, both from mothers who breast fed (MBF) and from mothers who formula fed (MFF). African American mothers who breastfed felt strongly that feeding their babies breast milk was a crucial aspect of assuring the baby’s best health and growth. As one MBF told me: “I knew that my baby being with me and getting my milk was the best way for her to grow and for both of us to heal [from childbirth], so I kept her with me all the time.” This statement also identified the belief that a mother knows and can provide what’s best for the baby more easily by keeping the baby in close proximity, as well as defining healthy as growth and recovery from childbirth. Another MBF said her primary value was “keeping [my daughter] healthy, keeping her alive, and making sure she is getting enough breast milk.” When asked how she knew that her daughter was healthy, she answered that her baby was gaining weight well and her pediatrician said “a growing baby is a healthy baby.”

MFF in this study also felt strongly that formula was the best option to assure the baby’s health. One MFF told me: “My baby thrived on [formula] and it was easier than trying to figure out how to latch him on. It was a no brainer for me and he turned out just as healthy.” Using weight as an indicator for early infant health enables mothers to substitute size for health, defining a fat baby as healthy without any consideration of whether fatness is necessarily in the best interest of the baby. Another MFF put it this way:

“I breast fed my older son, and it made me cranky and so fatigued that I did not even want to hold him. Bottle feeding [formula] allowed me to get more rest so I
could be a better mom, and my daughter was just as plump and healthy without getting breast milk.”

Once again, fatness is used synonymously with health. This image of a fat baby as a healthy baby is consistent with previous research on infant size. If mothers are getting the message that having a fat baby is the definition of health, then the goal of having a healthy baby can be met as long as the baby is fed either enough breast milk or enough formula.

**Value 3: Breastfeeding is valued, but exclusivity is not always possible**

Breastfeeding was identified as a value among key informants and MBF, but exclusive breastfeeding was more valuable to key informants than to mothers. Those experts who value exclusivity felt strongly that African American mothers do not understand why this should matter. An OBGYN/researcher said:

“Exclusivity is not valued. Giving some formula can impact supply and can create a cycle that makes breastfeeding harder to do consistently. [Black mothers] don’t understand the impact of supplementing on their milk supply and that not supplementing makes breastfeeding easier.”

A number of key informants felt strongly that exclusive breastfeeding was a critical component of infant health and is a concept that African American mothers should value. Informants expressed that not valuing exclusive breastfeeding was the reason why African American mothers are less likely to breastfeed than other groups. A CLC said: “They don’t understand that the minute you feed a baby formula, or feed them from a bottle, the baby has no incentive to breastfeed. Getting milk from a breast is harder so a baby will reject the breast if they know that a bottle can be made instead.”
But there were others who felt that exclusivity was not essential. One nurse/researcher/CLC said:

“There’s a group that feels a baby can only be fed directly at the breast and if you are not doing that then you are not really breastfeeding. It’s different for each of us whether what matters most is a baby getting breast milk or being breastfed directly. I have seen IBCLCs withhold a breast pump from mothers who wanted to pump because they have an ideology that the baby has to be at the breast.”

Such ideologies can prevent a mother who might have breastfed from doing so if she worries that exclusivity is a component of breastfeeding to which she cannot adhere. A Health Educator said:

“We tell mothers breastfeeding can take many forms. If they can feed directly, great. If they pump and the baby gets a bottle of breast milk, great. If they have to supplement breast milk with formula, that’s okay too if the baby still gets some breast milk. Making it so black and white is the reason so many Black mothers don’t breastfeed at all.”

African American mothers confirmed that ideologies about exclusive breastfeeding can discourage mothers from breastfeeding, although the MBF in this study did breastfed for at least the first thirty days. It was because some African American mothers did value exclusivity and considered it to be a critical aspect of their baby’s wellness that they changed their work schedules in order to remain home to care for their babies. However, MFF had reflections of the idea of exclusivity as well. One MFF said:

“I breastfed my older daughter, but my milk [supply] was low so I
supplemented. The pediatrician told me there was no point to breastfeeding if I used formula and it kind of made me feel like my milk wasn’t contributing anything. So I stopped nursing her and decided to stick to what works this time.”

This mother was dissuaded, perhaps unintentionally by the provider, from breastfeeding because of a perception that her milk was somehow inferior either in quantity or quality to formula. Such messages about exclusivity can undermine a mother’s decision to breastfeed at all rather than encouraging her to commit to breastfeed exclusively.

Messages that Discourage Breastfeeding (DBF)

The second objective was to identify factors that MCAM perceive as discouraging them from initiating or continuing to breastfeed. I hypothesized that African American mothers perceive breastfeeding as something for which they will be harshly judged, and that they receive messages either directly or indirectly which indicate that breastfeeding will compete with work and other highly prioritized values by African American mothers. Additionally, there is a lack of role models to provide supportive messages within their communities that encourage breastfeeding.

Discouraging message 1: Providers are not always encouraging or trustworthy

Because African American mothers are less likely to breastfeed, key informants shared that health professionals often assume that African American mothers will not breastfeed before they speak to the mother. The result sometimes is that African American mothers are not offered lactation assistance or education in hospitals. Assuming that African American mothers would refuse the assistance enables a type of discrimination that prevents African American mothers from receiving the support that lactation specialists are expected to provide all new mothers. One
Nurse/CLC has a strategy to ensure that she sees all new mothers when she is on duty at her hospital as a lactation expert:

“Some mothers tell the nurse they don’t want to see the lactation consultant, but I ignore the boards and make the rounds anyway. And wouldn’t you know it? I can get almost every mom to nurse the baby at least once. It may not last, but some try and fall in love with it.”

However, many medical experts do not take it upon themselves to offer assistance to mothers, and sometimes they do not assist mothers who do want the help. A nurse/researcher/CLC said, “I have seen African American mothers breastfeed, and yet I have worked with many nurses who assume they won’t breastfeed and they don’t even give them the time of day.” Those nurses may not realize that they are discriminating against African American mothers, but failing to consider every mother uniquely to offer the same support to all mothers creates the opportunity for racist assumptions to adversely influence the health of these mothers and infants.

There is a long documented history in the United States of African Americans and African Americans not trusting their providers. Jacobs and colleagues (2006) reported that physician greed, racism and offering experimental treatments for routine medical care can contribute to distrust of physicians. Consistent with these findings, key informants reported that African American mothers did not fully trust the counsel they received from their providers. One midwife shared:

“Sometimes my clients listen when I tell them how important it is to breastfeed, but other times I can tell they just want me to leave it alone. I don’t---I use every appointment to remind them how much better breastfeeding is for both her and her baby. But I know that long term, they don’t always follow through.”
In this instance, the key informant was advocating for what she believed to be in the best interest of her clients. Many patients, unfortunately, do not have advocates on whom they can rely. An OBGYN/Researcher told me: “Most Black mothers are less likely to be encouraged by a health professional to breastfeed unless they are lucky enough to have a breastfeeding advocate as a doctor or nurse, or have a parent or friend who told them what’s what.” And in some instances, the mother never hears any counsel from the provider. A nurse/CLC said that “Black mothers are more likely to arrive [at the hospital] with their minds set against breastfeeding, so they ask for a lactation counselor not to even come to the room. There’s no chance to even change their minds.”

It seems that African American mothers have good reasons for being suspicious of the recommendations of their providers. One MBF shared this heart wrenching story of her experience of a doctor pushing beyond the normal boundaries:

> “My doctor called me at home to say I should have an abortion because my baby would have Down Syndrome. It turned out she was wrong, he was perfectly healthy… So when she said that formula was just as good as breast milk, I didn’t trust her. I had to go online to find out that breastfeeding was better after all.”

A second MBF shared a terrible experience with a doctor that resulted in her not only not trusting the doctor but also remaining very angry about the experience some years later:

> “My doctor said the baby needed ‘fortifier’ because my baby was not gaining enough weight. Turns out they were mixing formula into my breast milk against my expressed wish for them not to do so. I was ready to kill him and the nurse. I already knew I could not trust him, but this just added fuel to the fire. They did not even apologize.” (MBF, baby was born prematurely at 27 weeks of age)
Above are two extreme examples of receiving poor advice and unreliable behavior from doctors, but the sentiment of not being able to trust a provider extends over to providers who provide sound counsel. A MFF shared this story about her midwife:

“My midwife encouraged me to breastfeed and she helped me latch the baby on after the birth, but she did not believe that I was not interested. She made it sound like good mothers breastfeed and bad mothers don’t, but my sister used formula and she’s a great mother. It seemed like she had an agenda, you know?”

While the intention of the providers may be to encourage the mothers to act in a way that allows for the best outcome for the mother and her baby, deceptive practices results in further eroding the fragile trust relationship that many African Americans have with their providers.

**Discouraging message 2: Loved ones sometimes teach that breastfeeding is wrong**

In the same way that having family support is valued by African American mothers, being influenced that breastfeeding is an unacceptable practice strongly discourages mothers from doing so. Many of the MBF (n=6 of 23, or 26%) expressed receiving a message from a relative or another member of the community that discouraged breastfeeding. One MBF said:

“I started to feed my daughter at my aunt’s house and she quickly ushered me into the next room so no one would see my breasts. I wasn’t concerned, but she made me feel self-conscious about nursing in front of others.”

Whether the aunt had been taught the same message or was protecting the mother for other reasons is unclear, but hiding the mother as though breastfeeding were shameful behavior left a lasting imprint on the mother.

Many more MFF (n=12 of 20, or 60%) reported being taught by the women in their family that breastfeeding was inappropriate behavior. One MFF said:
“My mother and mother in law said: ‘you don’t put a baby to sleep on their back, you put them on their stomachs’ and ‘you don’t take a baby home in a car seat, we didn’t do that 30 years ago’ and ‘breastfeeding in public isn’t what decent women do’. I didn’t really believe them, but I wasn’t planning to breastfeed anyway.”

Whether the mother’s decision to breastfeed was her own or was influenced by her family is unclear, given the strong opinions in her family against what they consider to be decent behavior. She stated that she did not believe that breastfeeding was an indecent behavior, but the discouraging messages can influence a mother’s values nevertheless.

Messages about decent behavior also come from spouses. As some mothers counted on support from their spouses, they also were influenced by spouses who held a negative view of breastfeeding. Another MFF said:

“I thought about breastfeeding this time, but [my spouse] thought that there was something sexual about it, especially since the baby was a boy. I think breasts are made to feed children instead of like fun bags for men to play with, but in the end I just wanted to avoid that drama altogether.”

In both this example and the previous, the mothers stated that they disagreed with the opinions expressed. Nevertheless, it is a possibility that each mother decided against breastfeeding her child in order to avoid the “drama” of engaging in a behavior that was not approved by close relatives. Because numerous MFF shared messages they had received that discouraged breastfeeding, it is hard not to wonder whether having encouraging influences might have resulted in more of them breastfeeding their babies.
Discouraging message 3: Public stigma against breastfeeding, especially for African American mothers

Similar to the messages that some mothers receive from relatives discouraging breastfeeding, there were messages from the larger community that conveyed a stigma against it. Key informants I interviewed were clear that the stigma that influences African American mothers not to breastfeed is particularly strong. A Heath Educator/CLC said: “Duration and initiation is lower, but there is also a public stigma in the Black community that is less prevalent among White and Hispanic mothers. Black mothers are aware of it and they care more what others think of them.”

A nurse/CLC further explained the stigma mentioned above. She told me:

“They don’t want to breastfeed where others can see them, so there is stigma affiliated with it. And I don’t just mean out in public. Black mothers tell me they get picked on for exposing their breasts at home. It’s a cultural stigma that follows them home.”

One MBF shared an example of this: “When I know my father or brother are going to coming for a visit, I make a point of feeding the baby before they come over because they told me before that seeing me breastfeed weirded them out.” When I asked how the rest of her family felt about breastfeeding, she said “I nurse in front of the women in my family just fine. When it’s just us, its not a problem.” This statement further complicates the stigma notion. In her family, breastfeeding was an acceptable behavior in which to engage with other women, but the stigma of breastfeeding in from of the men in her family elicited a discomfort that shifted her behavior even in her home environment.
The stigma does not seem to just effect public places or take place in interactions with strangers. A MFF shared this story in her church, an environment which she expected to find support:

“When I breastfed [my older daughter] once in church, I got some of the rudest stares. At first, my attitude was like, ‘my body, my baby, mind your business.’ But next time around, I decided it wasn’t worth all the effort, especially since bottles are so much easier.” (MFF)

Unfortunately, this experience had a direct effect on the mother’s future decision not to breastfeed. Another MFF explained why the stigma is different for African American mothers than for other racial groups:

“We can’t be perceived as doing stuff that White mothers get away with because we’re already suspected of being bad mothers or being on welfare with babies or what have you. White women can show their breasts all day in public and nobody will say a word. If I did something like that, my people would put me in check.”

The statement above indicates a fear that someone, likely another African American person, would have addressed her for breastfeeding publicly. Not only is there a risk of being publicly stared at, but African American mothers worry that they might be reprimanded as well by others for breastfeeding in public.

**Discouraging message 4: Mixed messages about the benefits of breastfeeding**

Not knowing the benefits of breastfeeding or receiving inconsistent messages about the effects of breastfeeding can discourage African American mothers from trying. A Trained Volunteer who teaches about the benefits of breastfeeding said: “[Mothers] may have some
knowledge of shallow benefits to her baby but not the deep benefits, and certainly not the fact that it decreases her own chances of breast cancer.”

But in order for a health provider to offer this information, the provider has to also be educated about the benefits. Knowing breastfeeding techniques and being educated on the nuances of breastfeeding and milk care requires specialized training that most mother and even some providers may not have. A midwife underscored this notion:

“[Mothers] don’t understand how to [breastfeed] better, how to store milk, who to call, where to turn when they need help. If they take medications, can they still breastfeed? You need an expert to help you answer these and many providers are not experts.”

Without access to a trained expert, the messages are easily confusing to new mothers:

“First they said put your babies to sleep on their stomachs, and then they said put them on their backs. They used to say breast milk was better than formula, but now they say formula is just as good. It’s so confusing to know what’s best and that’s all mothers really want, is to do their best.” (MFF)

Lack of access to this information, or inconsistent information, can lead an African American mother who might have otherwise breastfed her baby to utilize formula in hopes of doing what is most beneficial.

**Discouraging message 5: Competing demands interfere with breastfeeding**

Competing demands for time have a heavy influence on African American mothers’ decisions about how to feed their children. Sixteen MBF (70%) worked either part-time or full-time after the baby was born, while eighteen MFF (90%) worked either part-time or full-time. In addition, seventeen MBF (74%) and eighteen MFF (90%) had older children. The majority of
mothers in the study had competing demands for their time, and this was truer for MFF than for MBF. A postpartum doula spoke about the demands on African American mothers:

“Most Black women have demands on them at a high rate for income, demands that make breastfeeding seem unachievable. They either work all day and leave a caretaker to feed the baby formula, or they work all day and then breastfeed all night. No mother is going to keep that up for long, no matter how motivated she is [to breastfeed].”

Another key informant pointed out that African American mothers are less likely to have the support needed to manage the demands on them. A Health Educator/CLC said:

“Black women contend with jobs that offer no maternity leave, no work support for breastfeeding, pumping or milk storage. There is a lack of community support from partners to do what it takes to make breastfeeding stable. Across the board, breastfeeding is sabotaged for all mothers.”

This statement identifies the importance of work and community support for all mothers, but it also identifies that African American mothers in particular are less likely to have employer support to make breastfeeding possible. It also supports the next issue as well.

**Discouraging message 6: Lack of employer support**

The mothers I interviewed were all middle class at the time of their child’s birth, and yet the subject of having employer and legal support for extended leave arose as an influence that discourages African American mothers from breastfeeding. An OBGYN/Researcher said:

“Some specific things are family medical leave and not having enough time to spend with babies. Black women, especially low income, have the lowest rates of FMLA and have to go back to work quickly, but even middle income Black
women are more likely than White women to work in jobs where leave simply isn’t an option.”

The Family Medical Leave Act (FMLA) guarantees unpaid leave and job protection for the employee for up to twelve weeks for reasons that include maternity leave (USDOL, 2017). The key informant’s point about low income African American women is irrelevant to this study, but her statement about middle class African American women is relevant and may be true either because FMLA is not available or because they cannot afford to take unpaid leave (Diversity Data Kids(a), 2018).

Despite being middle class and having some education, African American women cited needing to work and concerns about returning to work as a primary motivator for not breastfeeding. Some of the key informant quotes listed under “Value 2: Good mothers who want independent children” speak to the idea that African American mothers foster independence in part so infant care can readily be passed to a caretaker when the other returns to work. In addition, one MFF who worked part-time said: “My job offered leave but it was unpaid and I could not afford to stay home.” Despite having her baby by cesarean section surgery, the mother returned to work within four weeks “against their wishes and mine, but I needed the job and the money.”

A MBF for whom taking leave was not an issue mentioned that she was aware this was an issue for other women. She said:

“My sister was back to work after three weeks, so I kept the baby. I told her that even three weeks of breast milk was good for my niece, but she did not want the hassle of switching and having a baby who might not eat well. By three weeks
old, my niece drank her formula like a champ and was sleeping long stretches already, which my babies never did at that age.”

Three issues are addressed in this quote. One is the topic of a mother (although not the MBF) not being able to take a long enough leave of absence from work to care for her baby. This is a common issue faced by African American mothers, though most common among low-income African American women (Diversity Data Kids(b), 2018). The second issue is that the sister anticipated problems with breastfeeding her daughter for a few weeks rather than seeing it as beneficial. Rather than offering breast milk during those early weeks, she supplemented with formula to prevent a problem she assumed was inevitable, a decision that she determined was in the baby’s and her own best interest. The third issue is the idea that babies who are fed formula are better eaters and sleep longer than breastfed babies. If this is a mother’s belief system and if she values having a healthy, well-fed, well-rested baby (per Value #1 of this analysis), then it seems clear that a good mother would feed her baby formula. This speaks to a perception of appropriate behavior for a newborn baby as well as the decisions that a good mother would make for her baby, despite the fact that these perceptions may be based on inaccurate information.

**Discouraging message 7: Mothers are taught not to trust their bodies**

The notion of insecurity and not being enough is pervasive, according to both key informants and African American mothers. A Health Educator/CLC summarized this idea nicely by saying:

“The issues are shared (by all mothers). ‘I don’t have enough milk,’ ‘I am afraid to hurt my baby,’ ‘I don’t have enough time,’ etc. and these become reasons others use against mothers that discourages them from breastfeeding.”
Exactly how these ideas presented themselves differed between MBF and MFF, but the sense of not being enough was felt by African American mothers from both groups. According to a MBF:

“My sister kept asking me why the baby wouldn’t sleep longer. I guess breastfed babies need to eat more often, and I was fine with that, but whenever I saw her it was like there was something wrong with my baby because she was up every two hours during the day. I thought maybe it wasn’t normal.”

This is an insecurity that the mother may not have had without receiving the message that a newborn baby is not supposed to wake often. Waking often to feed is normal infant behavior, but formula is very filling and causes babies to sleep for longer stretches than breast milk (Ball 2013). However, a mother who does not know this may worry that she is not producing enough milk or otherwise not able to provide physically for her baby. One MFF said she used formula because “the women in my family don’t produce enough milk.” She then told me that even though she knew this was true, she surprisingly “leaked milk for weeks before it dried up,” a phenomenon that she thought was strange. The evidence did not support her not producing enough milk, but receiving this message discouraged her from even attempting to breastfeed.

**Influential Factors (IBF)**

The third objective was to understand what influences MCAMs to either breastfeed or bottle feed their infants, or to change from one feeding option to another. I hypothesized that African American mothers’ decisions to breastfeed are influenced by how strongly they value breastfeeding, by how satisfied they perceive the baby to be after a feeding, and by the amount of support they have from spouses, relatives, employers and others close to and influential in the mother’s life.
Influential factor 1: African American mothers who know women who breastfeed are more likely to breastfeed

African American women are influenced to breastfeed by their experiences and their interactions on infant feeding. An OBGYN/Researcher said, “I hear a lot of mothers say to their pregnant daughter ‘I wasn’t able to breastfeed you, so I don’t think you will be able to breastfeed.’ Could she really not breastfeed? Chances are she had the wrong information but that same line gets passed down from one generation to the next.”

Table 4.14 (section above) supports this statement, as the majority of MBF (n=18 or 70%) were breastfed themselves as children (some exclusively) compared with fewer MFF (n=9 or 40%). Those who breastfed were more likely to know women who breastfed or to have grown up in environments where breastfeeding was either normalized or considered acceptable. One MBF told me:

“My grandma came [over] and I was leaking all over the place. She said, ‘is that all your milk? Oh, that’s good that you’ve got so much milk. That’s how it was for me.’ I don’t think she realized how nice that comment was. It’s awkward and hard at times, but she made me feel good, like I was doing a good job.”

The supportive words from the MBF’s grandmother helped to normalize an uncomfortable experience that the mother might otherwise have felt was discouraging.

By contrast, African American mothers who never experienced breastfeeding or whose environments ostracized mothers who breastfeed are less likely to breastfeed. As a Health Educator/CLC said: “Not seeing women breastfeed makes it harder for African American women because we rarely see another woman who has breastfed, especially who looks like us, in our family or our community.” A MFF supported this concept when she said simply: “I never
saw anyone get breastfed. There were always bottles around. I’m not sure how I would have felt about seeing the women in my family be so exposed anyway.” She seemed uncomfortable at imagining a childhood in a household where breastfeeding was normalized. Whether the mothers realized it or not, not seeing breastfeeding as a normal behavior influenced how they valued and prioritized breastfeeding their babies.

**Influential factor 2: African American mothers who feel supported by their families and their extended networks are more likely to breastfeed**

The influence of spousal, family and community support are important factors that influence a mother’s decision to breastfeed. One MBF had a unique level of support from her spouse after a long delivery in the hospital:

“I was so tired after I had the baby, and it took all I had in me to breastfeed her. People kept coming to the room, and finally my husband sat in a chair outside the door and would not let people come to bother the baby or me. He said ‘she’s feeding the baby, leave them alone.’ I never loved him more than I did that day.”

Knowing that her husband was willing to support her in breastfeeding the baby by creating the space she needed made a big difference to this MBF. Another MBF commented about the level of support available in her church for mothers:

“There is a small room next to the nursery that has a television screen and chairs. Mothers can use it to nurse their children and not feel like they are missing service. It used to be empty, but Pastor’s wife saw all these mothers leaving service to feed their children and I think they wanted us to all feel comfortable.”

Likewise, the messages that advocate feeding formula to an infant can be just as influential. As one MFF told me: “I always saw the women in my family loaded up with diapers and bottles. It
never occurred to me not to give my baby a bottle, especially when my doctor told me that formula is just as good nowadays as breast milk.”

The support of those close to the mothers matters a great deal to them. One nurse/CLC told me that her clients are all very susceptible to influence for the first few days after birth:

“When I do my rounds and find her partner or mother in the room with her, I make a point of addressing the other person as I speak to the mom. A new mother is so fragile that she will check with them to see if they agree with me. If I say breastfeeding is important for her and for the baby and the other person disagrees, any resolve she had to breastfeed goes out the window.”

Another key informant---a midwife---agreed with this idea. For this reason, she begins working with her clients early. She told me: “It’s important to discuss breastfeeding at every visit leading up to the birth and to make sure she and her partner are on board up front. By the time the baby is born, they already know to breastfeed because everyone has agreed beforehand.” More than making sure that the mother intends to breastfeed, she makes an effort to ensure that the family supports the idea and is planning for it.

Mothers echoed this notion. One MBF said: “It was going to be a commitment to breastfeed, so my whole family had to be on board with it. My husband had to pick up the slack because there was no way I could breastfeed around the clock and still cook, clean and take the kids to school.” Having family support was essential to her ability to breastfeed, as this mother felt she would not have been able to do so without her partner taking on some of her roles.

The lack of support had an effect on mothers as well. One MFF said:

“I planned to breastfeed this time, but my husband travels for work. I knew he would be gone a lot, so even though I tried [breastfeeding] in the hospital, when I
saw how hard it was going to be I let it go. And babies sleep better with formula. There was no way I could wake up all night long and still take care of [my older daughter] during the day.”

Another mother who did not have a partner available to help her instead relied upon her mother for support. One MFF said: “I told Mama I wanted to breastfeed, but she kept asking me how she could help me with the baby if I did all the feeding. I guess she was right.” The opinions expressed by loved ones and their agreement to either support or challenge a mother’s plans for how to care for her baby are critical to a mother’s commitment to her plans.

**Influential factor 3: African American mothers who know the benefits are more likely to breastfeed**

There is conflicting information about the benefits of breastfeeding compared with feeding a baby formula, which contributes to mothers substituting formula for breast milk. However, when mothers are informed about the benefits of breastfeeding for both mother and baby, they are more willing to commit to breastfeeding their infants. An OBGYN said:

“Black mothers don’t know that breastfeeding reduces the risk of their babies becoming diabetic, or that it reduces their own chances of developing breast cancer because we do not tell them. We assume it won’t make a difference, but isn’t it up to them to decide?”

All twenty-three MBF said that they chose to breastfeed because they knew it was healthier, but only a few spoke about their specific definition of how breastfeeding was healthier. Three said it reduced risk of ear infections and asthma, and two said it reduced risk of diabetes. One MBF said it reduced chances of developing allergies later in life. Two mothers said it reduced their chances of developing breast cancer. In contrast, nine MFF (45%) told me that
formula is the same as breast milk or as good as breast milk. Because the primary definition of health tended to be correlated with baby’s growth rate and sleep, many MFF considered formula to be as healthy as breast milk (and possibly healthier in the cases where they knew a baby slept better because of having formula). However, it was clear that many MFFs’ understandings of the differences were not based on clear knowledge of the benefits of breastfeeding.

**Influential factor 4: African American mothers who know how to breastfeed or who have resources to assist them with questions are more likely to breastfeed**

Breastfeeding is a skillset that requires training, exposure to an expert and practice. African American mothers were more likely to breastfeed when they had access to the training, had an expert or other resource available to assist with any questions they had. An OBGYN/researcher said:

“Young mothers need cell phone ready support available. A mother may not call me, but she will always have her cell phone in hand. There should be help available at her fingertips that tells her what to do, what’s normal, and how to troubleshoot when something goes wrong.”

This idea of having tips available suggests a resource that could be available to mothers anytime of day, including late at night when lactation experts or friends and family are sleeping. One postpartum doula said:

“They don’t know normal behaviors or what cluster feeding is, or how their bodies work, or that a breastfed baby won’t sleep longer than a few hours in the first few months. That feeling of feeding around the clock is daunting, and understanding that it evolves and changes would help to ease their worries.”
Key informants felt that mothers do not know what behaviors are normal in a baby, and as a result they tend to seek out the promises of fullness, longer satisfaction between meals and long sleep that formula promises to provide. Babies who are fed formula drink a greater volume of milk and tend to sleep for longer stretches, but this is not necessarily a sign of health as these babies are often more likely to become obese adults (Arenz 2004; Dewey 2009). In addition, night waking is a normal behavior among infants (Sadler 1994; Harrison 2004). But the misinterpretation that this means a baby is not satisfied leads many mothers to doubt their milk supply or to worry that breast milk is less satisfying or less healthy.

One MBF said: “I know that waking often is normal [for breastfed babies], but my mother kept trying to convince me something was wrong. She did not know any better.” However, a similar experience went very differently for a MFF: “The baby wouldn’t sleep longer than an hour or two in the hospital, and my mama convinced me there was something wrong with my milk. Soon as we switched to formula, he slept longer.” Having the insights into normal behavior for a new born might have empowered this mother to continue to breastfeed.

Strategies for Successful Breastfeeding (SB)

The fourth objective was to identify models or practices that have resulted in MCAMs’ successfully breastfeeding their infants. I hypothesized that successful models would offer education and support to mothers, partners and extended family rather than targeting mothers alone; that they seek to make breastfeeding attractive to African American families by including images of African Americans in educational materials; and that the education and support they provided would be culturally sensitive for African American families and address concerns of African American communities.
Successful strategy 1: African American women need examples of African American women who breastfeed

Both key informants and mothers agreed that having a African American mother as an example for breastfeeding has a bigger impact than seeing women of other racial and ethnic groups. A postpartum doula said:

“When [African American mothers] come to a [breastfeeding support group] meeting, they want to see another woman of color breastfeed first before they do it in front of other people. White women don’t seem to have that same anxiety about feeding in front of others.”

A midwife agreed with that African American women create a powerful example for other African American women. She said:

“I don’t believe that only Black or African American women can counsel African American women. As long as there is love and respect, any color can teach any color. But it creates more comfort when African American women can see someone who looks like them doing it.”

Mothers who successfully breastfed their children reflected this in their interviews. One MBF said: “[Breastfeeding] was something I saw my cousins do. They just couldn’t afford to buy expensive formula and the cheap stuff seemed kind of nasty. So when it came my time, I knew what to do and when I had questions, they helped me.”

These examples do not necessarily have to be within the mother’s own family. One MBF learned about breastfeeding and infant care from her job. “If I didn’t work where I do, I’m not sure I would have breastfed. The few members of my family who may have nursed never did it for very long.” Having the example available to her created an option that had not been created
in her family, and it may have a similar effect for other mothers who did not witness breastfeeding in the home.

**Successful strategy 2: Support from partners, family, friends, community is essential**

There have been a number of examples provided by key informants and mothers which explain the importance of having support in order to successfully breastfeed in the theme categories presented above. In addition, one MBF offered another example of having support from a spouse:

> “I think success requires having one-in-a-million support. When I was so tired I could not even get out of bed, my husband brought the baby to me to nurse, he brought food to me, he massaged my feet and told me ‘thank you for being a good mom to our son.’ It sounds corny, but at the time it was what got me through.”

Recognizing that a mother’s ability to successfully breastfeed depends upon the support and love she has available to her puts some of the responsibility for whether or not babies are breastfed with the families as well.

**Successful strategy 3: Educational materials and messages need to target African American mothers rather than “all mothers,” and to include roles for the rest of the family**

Two organizations with successful groups of breastfeeding African American women offered this strategy as being the most important. One Health Educator said:

> “The messages about breastfeeding benefits are already out there and reaching White and Hispanic women as they are packaged. African Americans don’t see these messages as being about them, so we have to re-brand breastfeeding as a Black health issue.”
Both organizations have designed education materials that reflect members of the communities they serve, which they believe encourages those groups to consider the material about them and for their use. However, as the key informant commented above, not reflecting the cultural group or groups to whom materials are distributed can result in those groups feeling as though the issue does not apply to them.

Including ways for the mother’s family to become involved also helps to keep the entire family involved in caring for the newest member of the family and also alleviates some of the child rearing responsibility that tends to be focused solely on mothers. One key informant commented:

“Fathers want to be involved but don’t always know what to do or how. Spelling out suggestions, such as holding the baby while the mother sleeps, changing diapers, or waking with the baby at night after the baby has been fed are great examples for how fathers and even grandparents can be involved with a baby. Feeding baby a bottle does not have to be the only way.” (Postpartum doula)

This sentiment is echoed by a nurse/CLC, who said:

“When I talk to my clients about breastfeeding, I don’t just focus on the mother. A mother is only successful if the whole community is successful. Fathers have to know their role in breastfeeding, and grandparents, friends, and even strangers have a role. Mama may do the work, but it takes a village to support mama.”

Making breastfeeding a priority for the entire family helps to situate mother in her appropriate role without creating a space where she feels alienated or overburdened. Also specifically addressing African American mothers and their families with these messages may ensure that this community become engaged in the dialogue about breastfeeding. One way to do this is to
share culturally-specific materials with African American families that explain the roles that both mothers and others can have in the process.

**CONCLUSION**

The research findings from this study are categorized into four primary groups. The first category, infant feeding values, explains how African American mothers define “good motherhood,” what they value in a healthy baby, and the extent to which breastfeeding is valued. The second category identifies messages that African American mothers feel discourage them from breastfeeding and includes untrustworthy health providers, lack of support from loved ones, public stigma, mixed messages about the benefits, competing demands, lack of employer support and the lack of self confidence instilled by the medicalization of breastfeeding. The third category identified factors that influence how mothers feed their infants and lists previous exposure to African American mothers who breastfed, family and community support, knowledge of the benefits and knowing how to breastfeed or how to obtain help with breastfeeding. The fourth category lists strategies for successful breastfeeding including modeling by other African American mothers, support and education campaigns designed for African American communities.

The findings of this research provide a contextual understanding for the choices African American mothers make about how to feed and care for their children. In my interviews with African American mothers and the professionals who support them, I learned that the choices African American mothers make, whether they breastfeed or formula feed their children, are in response to a directive to be a good mother. Good mothers raise independent children and provide for them the best they can. Additionally, I learned that a healthy baby is defined as one who is well fed, growing, and sleeping well early on. Throughout the interviews, group
meetings I attended and even from direct observations, I witnessed African American mothers making clear efforts to fulfill their definitions of being good mothers who raise healthy babies.

Whether a African American mother breastfed her baby or fed her baby formula, the decision was made thoughtfully and based on her experiences and the insights available to her. Many have not received the messages that breastfeeding offers superior health benefits to both mother and baby. However, even more powerful is the fact that some African American mothers who do know this information are unable to make use of it for a variety of reasons. Whether they are limited by the financial options, the lack of support from those closest to them or real fears of being ostracized or judged for parenting as they see fit, African American mothers remain in the position of sometimes being unable to value the benefits of breastfeeding over those provided by infant formula. After speaking with fifty-eight mothers and key informants, it was clear that infant care is an issue that provokes passion from mothers who make conscious choices when they can with the intent of doing their best for their children. Awareness of the primary values, messages and influences experienced by African American mothers is a critical piece to determining the best methods for supporting them as they care for their infant children.
Chapter Six presents a discussion of the research findings from Chapters Four and Five. It also describes the practical implications of these findings, suggests ways to improve the support available to mothers and others who care for infants, and explores the contributions this research makes to anthropology. From this sample of middle class African American mothers who both breastfed and formula fed their babies, as well as the health professionals who work with them, a number of primary themes emerged. The central issue is that the findings offer a culturally-determined definition of being a “good mother” that is specific to African American mothers. Having this data provides insights that can help health professionals to understand how African American mothers prioritize and determine how to feed their infants, insights that are critical for those concerned with increasing breastfeeding rates among these mothers. Following a brief review of these findings, I review the possibilities that other research has already considered, the areas that have not been considered and the novel perspectives and insights provided by this research.

**Participant Observation Discussion**

Between twelve visits and twenty-four hours of observation, I observed 108 mother-infant dyads across six observation sites. Twenty-seven of the mothers (25%) were African American, which is slightly higher than the African American population in Tampa Bay according to the most recent census (US Census, 2015). Twenty-eight of the mothers I observed (26%) breastfed publicly but African American mothers were underrepresented among this group (n=2), comprising less than 2% of the total number of mothers I observed. And the two
mothers I observed breastfeeding were unlike the other mothers who seemed oblivious or at least unconcerned by my presence or that of those around them. Rather, they seemed hyperaware as though they were engaging in a behavior that challenged was acceptable as normative.

Despite increased breastfeeding rates for all mothers in the past decade, Black mothers continue to be reported as the racial group least likely to breastfeed their children and also least likely to breastfeed publicly (CDC 2017). However, African American mothers do breastfeed their children. Mothers who participated in this study shared experiences of breastfeeding within the safety of their own homes and yet they still faced relatives who disagreed with the behavior and demonstrated their lack of support. Some mothers also commented that they faced opposition or ridicule while feeding in semi-public spaces around friends or known associates.

The notion of breastfeeding in public, open facilities such as the Tampa Zoo, Florida Aquarium, Glazer Children’s Museum, Dinosaur World or at a local park may hold less appeal to these mothers who have already become targets in what they considered to be safe spaces. The fears of being publicly “called out,” as one mother put it, are real enough to keep breastfeeding mothers confined to private spaces during infant feedings. This fear may explain in part why African American mothers also did not breastfeed in the majority of private breastfeeding meetings I observed.

One setting where African American mothers were successfully engaged in breastfeeding behaviors and felt comfortable doing so publicly was the breastfeeding support group meetings for African American mothers. Even though the meetings took place in public meeting spaces where strangers—men and women alike—could see their exposed bodies and their children, the mothers appeared to be neither disturbed nor anxious to cover themselves up while feeding. The presence of other mothers, perhaps other African American mothers, seemed to create a sense of
solidarity. This solidarity speaks to Bourdieu’s notion of embodied cultural capital. In settings dominated by other ethnic groups, the behavior of “we don’t do this” seemed the most prevalent practice of African American mothers with regard to breastfeeding behavior. However, in the presence of others of shared habitus and cultural capital, this public setting denoted a field where breastfeeding was something that African American mothers do, in fact, do.

**Descriptive Data and Themes Discussion**

There are characteristics that the twenty-three mothers who breastfed (MBF) in this study had in common. Breastfeeding mothers lived with a spouse and their child or children. They were older mothers at the time of baby’s birth, have at least four years of college education and were employed. Although these mothers worked in a variety of jobs, they were more likely to work in a health related position as a medical doctor, nurse, health educator, dietician or other role and they considered their jobs to be supportive of their pregnancies. They worked full-time prior to the birth of the baby and had the flexibility to change to either part-time work, home-based employment or to become a full time mother after the birth. They gave birth in a hospital setting, although 20% delivered during planned home births. They were more likely to have breastfed previous children and to have been breastfed themselves as infants. Finally, they were the primary caretakers for their children during the first thirty days of their baby’s life. While caring for their children, breastfeeding mothers sacrificed their time, their income in some cases and their bodies to fulfill their definitions of being a good mother. Their efforts to be good mothers included breastfeeding in order to provide what they determined to be ideal infant nutrition and contribute to securing optimal health for their children, both of which they believe would improve their capital.
Similarly, the experiences of the twenty mothers who formula fed their babies (MFF) offer insights into their decisions for infant care. They were younger mothers at the time of baby’s birth and had some (two years) college education. Although 15% planned home births, the majority of MFF delivered their babies in hospitals. They were more likely to have used formula with previous children and almost equally likely to have been breastfed, formula fed or to be unsure how they were fed themselves as children. They were more likely to work in paraprofessional administrative positions and felt their jobs were supportive of their pregnancies. However, these mothers returned to full-time positions after their babies were born. Even though the majority of MFF were the primary caretakers during the baby’s first month of life, almost half (45%) reported that they shared caretaking with a spouse, parent or a daycare provider. They lived with a parent in addition to living with a spouse and children, and they relied upon the support of their spouses and parents to assist with taking care of older children and meeting other family needs. Despite the competing demands on their time, they fulfilled their definitions of being good mothers by raising independent children and preparing them to be able to be cared for by fathers, grandparents and day care providers in the mother’s absence. Raising independent children enabled MFF to be hardworking, giving to their families and able to contribute financially for their families, which they believed helped to secure their children’s capital, a central tenant of being a good mother. And these mothers believed that a necessary component for being good mothers was the provision of infant formula, in part, because it enabled them to fulfill the broader role of being a good mother which included providing for their infants.

EMPLOYMENT, GOOD MOTHERHOOD, HEALTHY BABIES
Mothers in both the breastfeeding and formula feeding groups had high rates of employment during and after the birth of the baby. While most mothers felt their employers were supportive of their pregnancies, MFF were more likely to feel unsupported (25% vs. 8.7% of MBF) and they cited pressure to stay competitive in the workplace as a competing demand on their time. In addition to pressures to stay employed, MFF were more likely to work in service jobs than MBF, which tend to offer more limited maternity leave options. This is consistent with research that found Black women more likely to work in lower-paying service jobs (Ringel-Kulka et al. 2011; Smith-Gagen et al. 2014) and to have shorter maternity leaves when compared with women of other ethnic groups (Johnson et al. 2015; Spencer & Grassley 2013).

Workers with higher wages are more likely than workers who receive lower wages to have a paid maternity leave benefit. Additionally, studies found that approximately 14 percent of management, professional, and supervisory positions offer a paid family leave option while only 5 percent of service, 9 percent of sales and office, and 4 percent of industrial workers have the same benefit (US Dept. of Labor 2007), positions which were held more often in this study by MFF than MBF. Mothers in these positions may feel less comfortable asking for time or a safe, sanitary space within which to pump breast milk, and if they worry that they could lose the job by asking for special concessions then they will be unlikely to ask (Smith-Gagen et al. 2014; Spencer et al. 2015). It is unknown whether MFF who did not have a paid maternity leave option would have breastfed if the option had been made available.

However, what is known is that the identity of “good motherhood” for many of these African American mothers is predicated upon being a working woman and included being hard-working, strong, responsible and generous with one’s family in the definition of the term. Thus, unlike the measure of good motherhood for middle class White mothers which includes, to some
extent, “unlimited self sacrifice” (Ludlow 2012, p. 292) in the form of staying home to breastfeed and care for an infant, good African American mothers also respond to a social mandate that includes working outside of the home in its definition. Those who prioritize work over infant care risk being categorized as “failed mothers” (Fraser 1989, p. 2) while those who prioritize infant care over work may be considered failed mothers for not providing for their children. In either case, the expectations of good motherhood as delineated by African American mothers would preclude many mothers from either leaving jobs or prioritizing extended maternity leaves over working and contributing financially to the family.

Raising a healthy baby was identified as another key part of the duty of a good mother. African American mothers defined a healthy baby as one who eats well, sleeps well, functions independently of mother and in some cases was defined non-specifically as a “big” baby. Although not indicated in this research, this may be influenced by concerns that babies born at low birth weights, which are more common among African Americans than other ethnic groups (Collins et al. 2004), are at risk for disease and early death. When compared to low birth weight babies, the idea that big babies are healthy is a logical one. However, it is a common misconception among ethnic minority groups, and mothers who hold this belief may be encouraged to supplement breastfeeding with formula if the infant is perceived as being lean and, therefore, unhealthy (Office of the Surgeon General 2011). This is troubling, as the misguided belief that “big is healthy” can also lead mothers to overfeed babies or to introduce solid foods to babies when they are too young (Heinig et al. 2006). It can also contribute to other behaviors that are inappropriate for very young babies in the attempt to make them function like older, less dependent children.
MCAMs expressed hope for their children to be healthy, independent, to become educated, be successful in their careers, and live happy lives. This, in turn, delineated the actions of a mother who wanted to be a good mother, whether she choose to breastfeed or formula feed her baby. Knowing that African American mothers acted as agents on behalf of their children through her choice of food provides tremendous insights into what motivated their behaviors and how to best approach developing strategies for change.

Socioeconomic Status, Age and Education

One important distinction between this and other studies is the inclusion of middle class African American mothers only. Few studies of breastfeeding and socioeconomic status (SES) have used more than one dimension of income status to consider the factors most predictive of breastfeeding. Two studies that used both income and education still surveyed primarily low-income women (Evers et al. 1998; Mitra et al. 2004). One broader study of women in a Boston group practice (Celi 2005) found that maternal education and household income were both significant in predicting breastfeeding initiation, but that education was more important than income. Another study found education and income status to equally predict breastfeeding initiation (Yang 2004). The decision to exclude low income Black mothers from this study provided a unique opportunity to examine whether SES is the only powerful predictor of breastfeeding behavior as several other studies have indicated (Beck et al. 1999; Roe et al. 1999; Ryan 1997; Evers et al. 1998; Nolan & Goel 1995; Scott et al. 2001), or whether there are others. The validity of these findings have important implications for researchers who continue to only target study efforts towards low income populations.

This study found that even when controlling for socioeconomic status, numerous other factors predict breastfeeding behavior. Beginning with age, I discovered that among MBF,
65.2% were 25-34 years old and another 21.7% of mothers were 35 years or older when the baby was born. MFF, on the other hand, were mostly 18-24 years old (55%) at the time of birth with another 30% ages 25-34. This finding was consistent with previous research which showed that older mothers are more likely to breastfeed (McDowell et al. 2008).

Maternal education appears to be an important predictor as well, a finding that is consistent with previous studies which found maternal education to be a more accurate predictor of breastfeeding than income (Evers et al. 1998; Celi et al. 2005; Fein & Roe, 1998) or employment (Fein & Roe, 1998). While most study participants in both groups had at least some college education (two years), more MBF had a bachelor’s degree or a graduate degree than MFF when their babies were born (65.2% and 40% respectively).

Maternal education level could account for MBF’s knowledge of the benefits of breastfeeding, being that education is correlated with knowledge of health behaviors (van Rossem et al. 2009; Heck et al. 2006). These mothers were more likely to work in positions as health professionals, so this could also account for their knowledge of breastfeeding benefits. However, education could also account for having the types of jobs that enable flexibility to either reduce hours from full time to part time, to work from home, or to make adjustments that allow for breastfeeding or pumping during the work day.

COMPETING PRIORITIES AND FAMILY SUPPORT

The mothers in this study did not raise and care for their families alone, which adds another level of infant care for consideration. A working mother needs support at home, and the level of support that MCAMs received was another important factor that influenced how they fed their infants. Researchers found that if the mother’s spouse was supportive of breastfeeding, the mother was more likely to breastfeed than she would be without the support (Bentley et al. 2003;
Fathers can be a significant source of support or discouragement when it comes to breastfeeding (Arora et al. 2000, Wolfberg et al. 2004), and both perspectives were shared by mothers I interviewed. MFF who intended to breastfeed sometimes changed when challenged by an unsupportive partner, a finding also supported by research (Wojcicki et al. 2010). Those who breastfed were more likely to have spousal support and encouragement while mothers who formula fed were more likely to have a spouse who either expressed an opinion against breastfeeding or who did not provide the support that would enable the mother to breastfeed.

Additionally, mothers who lived with a parent were more likely to use infant formula than mothers who resided only with a spouse and their children. The grandparent was either the mother’s mother or her spouse’s mother and in some cases included both the grandmother and grandfather. Grandmothers have been found to have significant influence on a mother’s decisions and practices relative to feeding her infant (Ingram & Johnson 2004; Bentley et al. 1999). A grandmother who breastfed her own children, for example, has been found more likely to share her experiences and is better able to support another mother who breastfeeds her own children (Grassley & Eschiti 2008). Likewise, a grandmother who did not breastfeed is more likely to discourage it and to suggest using formula (Grassley & Nelms 2008). A MCAM’s connections with her mother and her grandmother demonstrated the effects that transgenerational beliefs and experiences of infant feeding had on the mothers’ intentions for her child. Previous studies have found mothers were more likely to breastfeed if they had a relationship with family members or friends who breastfed their own children (Spencer & Grassley 2013; Wiemann et al. 1998).
A novel finding in this study was that being breastfed as a child also appears predictive of breastfeeding behavior in mothers as well. 56.6% of MBF reported being breastfed as children and another 21.7% received a combination of breast milk and formula, for a total of 78.3% of MBF being breastfed. In contrast, MFF were almost equally as likely to be breastfed (n=6 or 30%) as they were formula fed (n=5 or 25%) or to be fed in a way that they could not recall or were unaware (n=5 or 25%). This is not surprising given that low rates of breastfeeding are believed to be a transgenerational experience in African American communities. However, it confirms the role of habitus and how African American mothers’ early experiences with breastfeeding may later influence their decisions of how to feed their own children.

MFF were both more likely to live with a grandparent (65% of MFF vs 17.3% of MBF) and were also more likely to share primary caretaking very early on (50% MFF vs 13% MBF). Mothers who planned to return to work and to share caretaking of their newborns may have been encouraged to use formula by experienced relatives who viewed breastfeeding as an obstacle to mothers getting enough rest or with infant feeding once the mother had returned to work, as others have found (Grassley & Eschiti 2008). MFF were likely to heed the counsel of older female relatives, as research has also shown mothers want their mothers to be supportive of them and the decisions they make for their infants (Grassley & Eschiti 2008).

Beyond needing support from immediate family members, MCAMs perceptions and decisions were in response to the breastfeeding advice offered by friends and peers. Previous studies found that negative and unsupportive comments from friends have dissuaded Black mothers from wanting to breastfeed (Lewallen & Street, 2010; Meyerink & Marquis, 2002; Spencer et al., 2015; Street & Lewellan, 2013).
Although some MBF committed to breastfeeding in spite of antagonistic comments, the majority had the support of loved ones and depended upon that support. MFF also felt supported, but they were more likely to have loved ones who disagreed with breastfeeding, although MFF often commented that they had not intended to breastfeed anyway. What mothers may not realize is the subliminal influence that the dissenting opinions likely had on how they valued breastfeeding in comparison with formula. In addition, MFF expressed greater concerns about the possibility of being publically stigmatized for breastfeeding, whether by people known to them or by strangers.

**Breastfeeding Benefits**

MCAMs had mixed knowledge of the benefits of breastfeeding, and this contributed to mixed feelings about its importance. The MBF in this study were aware of the benefits and went to great efforts to exclusively breastfeed. MFF, on the other hand, either were aware but felt that the constraints on their time justified not breastfeeding or they considered breastfeeding to be equal or inferior to using formula. Mixed knowledge of the benefits of breastfeeding resulted in mixed insights into the value of exclusivity on behalf of MCAMs. Health professionals, on the other hand, seemed clear on their positions that all mothers should breastfeed exclusively. This speaks both to a failure to communicate this importance to mothers and and failure on the part of health professionals to understand the priorities in a African American mother’s experience that make exclusivity impossible. Awareness of the challenges that mother’s face might help providers better relate to mothers on this issue, as it’s been shown that knowledge about the benefits of human milk was associated with higher initiation of human milk feeding and increased duration (Caulfield et al. 1998; Stuebe & Bonuck 2011).

**Health Professionals**
The influence of professionals on this population is enormous, considering that they are the first previously unknown influence on mothers. And yet, mothers expressed a sense of distrust of providers and the information they offer about infant care. The history of African American communities not trusting providers is well documented and this study found the lack of trust of the infant feeding information provided by health providers to be consistent with previous studies (Bentley et al. 1999; Cricco-Lizza 2006; Ringel-Kulka et al. 2011; Spencer & Grassley 2013). Given the medicalization of breastfeeding and campaigns of the medical and formula industries to discourage confidence in mother’s breastmilk and encourage her to supplement with infant formula, the uncertainty with which African American mothers receive counsel from health professionals is founded. Current messages that encourage breastfeeding may be met with the same receptivity as any message from an untrustworthy source, and MCAMs in both groups expressed this viewpoint. This lack of trust might also explain why education materials designed and marketed to African American mothers who do not breastfeed have yet to make the inroads desired in influencing them.

**STUDY LIMITATIONS**

There were several limitations to the current study. The qualitative sample of forty-three mothers is not representative of all middle class African American or Black mothers living in Tampa Bay, Florida. The mothers who were included in the study represent the extremes of mothers who used breast milk or formula exclusively. A more inclusive study that included mothers who fed their children both breast milk and formula might offer insights into the factors that cause mothers to switch from one to another or insights into why mothers choose to use them both. Also, a study that investigated cultural variation between ethnic groups within the “Black” census group category, as well as comparing various Black groups of mothers in the
southeastern United States with Black mothers in other regions of the country, would provide a broader perspective.

All participants were mothers born in the US and identified as Black or African American. Foreign born mothers may have experiences of Blackness that are consistent with those of the mothers studied, particularly with respect to their interactions with providers, employers and society at large. Because the intention of this study was to understand the experiences of African American mothers with similar histories and cultures, the insights that foreign-born mothers might have added are missing. Also, the mothers who were included in this study were recruited using sampling techniques designed to be as inclusive as possible of the target population. For this reason, the sample is neither random nor accurately representative of all areas across the Tampa Bay region.

Additionally, to minimize bias, the interview questions were non-specific with regard to infant care. Detailed opinions about the use of breast milk, formula, and other aspects of infant care related to diapers, sleeping arrangements, or the events that occurred after the initial thirty days of the baby’s life were not collected. The limitations are areas of interest that could warrant closer examination in a future study.

**Practical and Theoretical Implications and Strategies for Supporting African American Mothers**

The needs of African American mothers have been well studied and documented, and a number of initiatives have been enacted to encourage low-income African American mothers to breastfeed. Many of these focus on educating the mother and, in some cases, educating their spouses about the importance of breastfeeding for the health of both mother and baby. These efforts tend to represent a targeted solution, however, based on the assumption that poor African
American mothers are the root of the problem. However, this research supports the need to reframe what health researchers define as the problem. The findings shed light on additional factors which demonstrate the need to assign responsibility to factors outside of the mother. In addition, they shed light on the factors of greatest importance about infant care to African American mothers. Rather than developing strategies to get them to conform, the most effective strategies would be those that support African American mothers to breastfeed while fulfilling the aspects of being a “good mother” that they find most important. Doing so creates the opportunity to develop new ways for these mothers to obtain the breastfeeding benefits determined by science while remaining loyal to their own values.

TARGETING INDIVIDUALS: EDUCATION AND SUPPORT FOR AFRICAN AMERICAN MOTHERS, FAMILIES AND COMMUNITIES

Messages that state that Black mothers do not breastfeed are inaccurate and should be revised to be more honest and positive. According to table 2.2 (see p. 31), Black mothers are the least likely to initiate breastfeeding but two-thirds of babies are breastfed nevertheless. Efforts, then, should focus not only on increasing the number of mothers who initiate breastfeeding but also supporting breastfeeding mothers so that they continue in a capacity that they find sustainable.

While education initiatives alone have not proven successful at closing the gap between Blacks who breastfeed and other racial groups, breastfeeding education and awareness should continue to be addressed to African American mothers, as the findings show that mothers do have some confusion about current evidence-based practices for infant care. However, these efforts should be expanded to include middle and upper income mothers as well. Making the assumption that educated, middle income African Americans do not need to be addressed takes
an assumption that perhaps applies to other ethnic groups and extends it to African Americans. Efforts that seek to educate low-income, uneducated African Americans leaves out an entire population which, this study has demonstrated, still lacks clarity about the differences between using breast milk and infant formula in infants.

Education efforts should also extend to the entire family since mothers rely heavily upon their loved ones for support, including the baby’s father. Fathers can have a powerful influence on whether or not a mother breastfeeds his child. Studies of African American families in which fathers are educated about breastfeeding and infant care found a 20% increase in breastfeeding rates (Arora et al. 2000; Bar-Yam & Darby 1997). This finding demonstrates the potential influence a father can have on the mother’s feeding behaviors and offers an additional method of ensuring a mother is supported if she decides to breastfeed.

Because mothers also seek the approval of grandmothers, education efforts that include the extended family have a greater likelihood of having a transgenerational effect that shifts the dialogue and acceptance of breastfeeding within African American families. One initiative that taught both fathers and grandmothers about the benefits of breastfeeding, practical techniques for how to breastfeed, and also equipped participants with tools for offering emotional support to mothers was well received by attendants (Ingram & Johnson 2004).

Education initiatives should be co-facilitated by Black and African American mothers and trained professionals when possible in order to engage mothers and gain their trust. In the presence of others like themselves, this research found that African American mothers were more likely to breastfeed, appeared to be more at ease and were receptive to the information shared. The model of African American mothers who teach breastfeeding techniques and demonstrate breastfeeding to other mothers can be a very successful method for educating,
troubleshooting problems that breastfeeding mothers face and providing emotional support. Black women who are able to become trained as health educators, lactation counselors and peer counselors could become health providers who are trusted and championed by their communities.

One benefit of this support group model is that encourages a shift in how breastfeeding is valued and considered socially. Supportive conversations that include mothers and fathers of infants as well as a transgenerational component that includes grandparents and siblings offer the potential to rebrand messages across multiple groups within the Black community about breastfeeding, including how it is done, who it benefits, and how to normalize it. The effects could be amplified if meetings were to take place in settings that include Black churches, community centers or businesses. This model sets the stage for reformulating the infant feeding habitus of African American and Black mothers, fathers, grandmothers and families. Thus, it offers potential to increase and perhaps normalize exposure to breastfeeding, which could offer powerful contributions to shifting how it is embodied by future generations.

Such initiatives should be made available in a number of convenient locations that are easy for new mothers to access in communities across the Tampa Bay area. Teaching the importance of proper infant care techniques in settings that include hospitals and clinics, local churches, community centers, libraries and recreational facilities such as the Aquarium and the Zoo could help to normalize breastfeeding and demonstrate an opportunity for widespread community acceptance. Such an initiative would help to shift the public paradigm of breastfeeding by eliminating stigma and perhaps creating new avenues of support to African American mothers and families in the process. This shift could have far reaching implications, perhaps even changing the field of breastfeeding in the African American community to being a
normative practice, which would thus shift how African American girls and women conceptualize of infant feeding from childhood.

Because the assumption from mainstream America is that good mothers do breastfeed, or that they at least try, the efforts presently underway encourage mothers to meet the gold standard for infant feeding: breastfeeding without supplementing with infant formula. “Good motherhood” is rarely considered to be incompatible with breastfeeding, except as some African American mothers in this study defined it. Having this insight into how African American mothers perceive the options for infant feeding paves the way for new strategies to support breastfeeding efforts.

African American mothers who are educated about the benefits of breastfeeding and who are supported by loved ones may still need to work outside of the home. Breastfeeding education focuses on teaching mothers why breastfeeding is good for them to do, and there are handouts distributed by the Centers for Disease Control and Prevention on topics related to how employers can support breastfeeding and how to increase support for breastfeeding in the workplace (CDC 2016). The handouts encourage mothers to request designated spaces where they can pump and store breast milk. Employers are urged to provide maternity leave for mothers, to enforce breaks so mothers can pump breast milk and to designate spaces for them to do so. Unfortunately, these messages were designed for office workers who hold jobs that provide benefits, an option that does not apply to independent contractors or hourly employees. The recommendations assume that women work in locations where pumped breast milk can be refrigerated during the day and work in companies that have the physical space to designate space for pumping. The recommendations also assume that mothers have access to breast pumps
and related accessories, but breast pumps, bottles, and storage packs can be cost prohibitive for some.

One strategy to support African American mothers who need to work, even if they must work while infants are very young, is to encourage them to breastfeed during the early weeks of a baby’s life before returning to work. Researchers have found that tremendous health benefits are imparted to newborns from colostrum, the milk that babies receive in the first few days of life (Anatolitou 2012; Underwood 2013). Even without extended breastfeeding, early initiation of breastfeeding imparts vital immunological benefits that protect an infant from autoimmunity, obesity and diabetes, cardiovascular disease, high blood cholesterol, high blood pressure, various conditions that cause diarrhea, and dental caries among others (Anatolitou 2012). Breastfeeding, even if limited to the first few weeks, is one scientifically supported way to fulfill the goal expressed by African American mothers of raising healthy babies.

The goal of exclusive breastfeeding may compete long term with the work responsibilities valued by African American “good mothers,” but breastfeeding early on has been shown to provide benefits even if it cannot be continued (Agostino et al., 2009). In fact, an international group of scientists in Europe wrote a commentary expressing that the benefits of breastfeeding are so vital that while “exclusive breastfeeding for around 6 months is a desirable goal … partial breast-feeding as well as breast-feeding for shorter periods of time are also valuable” (Agostino 2009, p. 123). Adopting this perspective of breastfeeding without insisting that breastfeeding be done exclusively or long term would allow African American mothers and infants to share in some of the benefits of breastfeeding.

Although it was not the focus of this study, research has found that mothers who breastfeed short term often stopped because of uncertainty about technique, baby’s satiety and
falling short of their own highly idealized expectations (Mozingo et al. 2000). A shift in mother and provider expectations of breastfeeding might help to reduce the cessation rates, and it could also help to reframe the experience of short term breastfeeding from one of “failure, guilt or shame” (Mozingo 2000, p. 120) to one in which mothers and infants were able to experience the benefits of short-term breastfeeding. Removing the pressure to exclusively breastfeed or to breastfeed long term might also eliminate the pressure some mothers feel to either perfectly fulfill the mandate of a breastfeeding gold standard or not risk trying. Instead, it could be replaced with both middle class Whites and middle class African Americans re-defining a “good mother” as one who provides what their families need, including short term breastfeeding at minimum, or providing for them financially if needed, or both for the mother who so chooses. Supporting a mother’s stated goals for infant feeding is a better way to ensure that those goals will be sustained long term (Miller, Louis-Jacques, Deubel and Hernandez 2018).

**Extended Support and Education from Health Professionals and Medical Settings**

There is no question, given the many benefits attributed to breastmilk, that all mothers should be taught how to breastfeed and also made aware of the health benefits and risks. However, anthropologists have taken the perspective of learning from communities first to better understand the experiences, values and barriers that may prevent them from breastfeeding regularly and to determine the appropriateness of breastfeeding to the circumstances of the mother’s life. There can be instances, for example, when breastfeeding is neither the optimal choice, the easy choice nor a possibility even though it might be considered ideal in other settings.

Health and lactation professionals who struggle to reach African American mothers might find themselves more successful if they followed the efforts of anthropologists and began
with observing how African American mothers interact differently with their infants in various environments. If unable to make observations directly, another approach would be to simply utilize the insights offered by anthropologists who have studied African American mothers, including this research, and made these valuable observations to help fill in the missing elements for bridging the gaps with African American families. It would be inappropriate to consider these findings as transferable to other Black cultural groups, although it is very likely that each subgroup may define "good motherhood" uniquely. The issue certainly warrants further study. However, practitioners can now begin to use a sensitivity to this issue when addressing any ethnic minorities by assuming that definitions of "good motherhood" and their manifestations are culturally bound and, therefore, not universal.

Health providers, particularly those who provide treatment to mothers and infants such as obstetricians, nurses, certified nurse-midwives, and pediatric caregivers, have ideal opportunities to engage mothers in discussions of infant feeding options. Health professionals should be equipped with accurate knowledge of breastfeeding techniques and should then use that knowledge to meet mothers where they are. An open and honest dialogue between mothers and providers that addresses all aspects of breastfeeding is essential to making a true connection, dialogue that begins with a professional first learning from a mother’s experience before determining what type of support to provide. While a health professional’s goal may be exclusivity, for example, vilifying or condemning a mother who is unable or unwilling to breastfeed exclusively might serve to further distance her from any breastfeeding. Professionals have a responsibility to teach mothers about the benefits of breastfeeding, whether or not a mother is able to conform to the gold standard of exclusivity as determined by health professionals.
To this end, professionals in hospital settings in particular should consider engaging all mothers in dialogue about breastfeeding their infants, even if the mother has already expressed an intent to use infant formula. Learning about her motivations may help professionals determine ways to breastfeed and still help the mother meet her priorities. Because lactation professionals in particular are often very busy and may only have time to visit patients who plan to breastfeed, hospitals may need to either broaden their lactation support staff or consider training volunteers who can offer added support to mothers in the hospital setting. And as suggested above, inviting organizations with experience engaging African American mothers and communities in to facilitate or help design a program within their organizations could be an effective means of bridging funding and facilities with expertise.

In addition, it may be that the biases my research identified that some health professionals hold about African American mothers need to be further investigated. Training of staff should include infant care skills as well as skills for engaging people of different ethnic groups. Because this may not be the expertise of clinicians and may detract from the roles they are trained to perform, working closely with trained anthropologists who are skilled with these insights and how to apply them to various populations is highly recommended.

TECHNOLOGICAL SUPPORT

One key informant suggested that technology is an area where support for mothers could be developed. Her suggestion was that mothers should be able to access information on breastfeeding and other infant care practices through an electronic resource in the form of a cell phone app. An example, latchME, is an app with resources that support breastfeeding mothers to connect with lactation professionals and other breastfeeding mothers. Other programs, such as Baby Tracker, allow mothers to track feedings by date, time and amount, along with details
about the baby such as diaper changes and health status. However, an app that could provide resources similar to an FAQ that was accessible around the clock might offer support when a mother has a problem and needs to brainstorm solutions at night when lactation professionals are unavailable.

**SHIFTING EMPLOYMENT POLICY**

Finally, policy should be developed that provides specific mandates to employers that specify what their roles should and should not be with regard to pregnant women and new mothers. Because even middle class African American mothers are less likely than their White counterparts to ask for simple concessions to be made to support their breastfeeding efforts, creating national policy would ensure that mothers can take breaks to pump and store milk, can receive paid leave, and feel entitled to ask employers for what they need to support their efforts to care for their infant children. What is asked of employers is some flexibility and willingness to support mothers during this short time.

The US government encourages employers to enact programs that support mothers who breastfeed, but they have not implemented policy changes to solidify the recommendations. Enforcing these suggestions by creating policy is one way to address this. An alternative could be to offer tax incentives to employers to provide support programs for female employees, such as making breast pumps available for employees to borrow, offering flexible work hours for employees with children under one year of age, or even allowing mothers to bring babies to work in cases where it is safe and convenient. The willingness to shift employment policy or practice is increasing as the social capital of breastfeeding increases. This process will take time, but as breastfeeding becomes a behavior that is valued and prioritized by those in dominant positions,
then shifts can be more easily made to institutionalize support for mothers in a variety of employment settings.

**CONCLUSION: CONTRIBUTIONS OF THIS RESEARCH TO ANTHROPOLOGY**

This study informs anthropological understanding of the role of infant feeding behavior in African American families and discusses how this role is influenced by the definition of being a “good mother.” MCAMs and the health professionals who work with them convey that infant nutrition is about more than nourishing the infant’s body for this community. How an infant is fed reflects how the mother and, in some cases, how the infant’s family embodies breastfeeding and infant formula use. Also, infant feeding behavior is an expression of the social circumstances within which an infant is born and raised, and it becomes a reflection of the values of those circumstances.

According to study subjects, African American mothers are aware – and oftentimes well educated – about the benefits of breastfeeding, despite being the mothers least likely to breastfeed in the US. In some instances, mothers made decisions that conflicted with what they considered to be best feeding choice for their infant because they had competing demands that took precedence. In other cases, mothers were able to change their jobs and their roles within the family in order to accommodate what they considered to be most valuable.

The mothers I interviewed expressed a commitment to the health and wellbeing of their babies. Their stated intentions were to fulfill their personal definitions of being a “good mother.” Although it has been argued that breastfeeding responds to the call of being a good mother as offered by the ideology of intensive mothering, it does not necessarily indicate that a mother is more committed to her child or to being a good mother. This study provides evidence that there
are many similarities between both those who breastfed and those who used infant formula in their efforts and commitments to being good mothers to their infant.

However, breastfeeding can be an important means of demonstrating the concepts of habitus and capital, and showing how they can be impacted by social structures and individuals alike (Jenkins 1992). MBFs who were raised with breastfeeding as a normative behavior embodied the dispositions and preconscious practices that reflected the social structures that shape them. Likewise, MFFs who were raised with infant formula as the accepted feeding modality reflected a similar influence of habitus in their decisions.

Bourdieu explained how individuals shape and are shaped by fields in which they interact, their positions relative to others in these fields and how to access and utilize resources in the form of capital (Bourdieu 1985). In this instance, African American mothers embody the habitus of “good motherhood” that for some may include breastfeeding, being a full time mother, or sacrificing time away from children or financial sacrifice. For other mothers, the habitus of “good motherhood” may include sacrificing time with the infant in order to provide, or to care for older children, or a number of the tenants that the intensive mothering movement defines as being a “good mother.” Both groups of mothers felt strongly that they were fulfilling the tenants of good motherhood as they defined it, and they believed that the sacrifices and contributions they made towards their children’s lives made the strongest contributions they could towards securing their child’s future capital.

Bourdieu’s theory of cultural and social capital provided a theoretical framework for understanding the early infant experiences of African American mothers and the complex interactions among habitus, capital and fields in the decisions they make for infant feeding. The decisions are heavily based upon the habitus a African American mother carries for “good
motherhood” which may include an “infant feeding habitus.” Both of these embodied beliefs intersect with her notions of having a healthy baby that she raises to be independent and for which she provides adequately, notions which are part of her value capital. Mothers believe that by raising their children in the manner they choose, they are creating the best capital for their own lives and for their children as well, as well as the best opportunities for a successful future. A working mother with responsibilities for providing and caring for a household must consider her job an important form of capital that supports her abilities to be a good mother, to raise her healthy baby and provide for him or her. For this reason, if using formula enables her to prioritize her job and supports her value structure, then we are able to understand the logic of her practice to use formula instead of breast milk.

The practical implications suggested in this chapter address two important issues that can compliment one another. Health professionals want to encourage all mothers to breastfeed, exclusively when possible, for at least a year. African American mothers want to be good mothers and some breastfeed for this reason, to the extent that it supports how they define being a good mother. Other mothers do not breastfeed because, in part, of the ways that not breastfeeding enables them to be good mothers. When a mother struggles to both be a good mother and to breastfeed, alternatives such as those presented above may be effective strategies that enable her to obtain the benefits of breastfeeding without compromising or losing her values.

This study offers a number of contributions to theoretical understanding of capital and motherhood and to practical understandings of motherhood in the context of present day realities:

1. It provides a contemporary context for understanding Bourdieu’s social theory by demonstrating mothers’ experiences of early infancy from recent years in Tampa Bay.
It also offers an explanation for the role of capital in influencing the infant feeding choices made by mothers.

2. It compares the experiences of African American mothers with the professionals who support them, providing a type of emic and etic comparison.

3. It contributes to anthropological understanding of capital as valued by mothers in present day and the effect of habitus on how mothers approach the task of mothering, including the infant feeding choices that mothers make every day.

4. It offers insights into the parenting model for how definitions and applications of “good motherhood” differ between African American mothers and other ethnic groups.

5. It offers insights of motherhood from the perspective of middle class African American mothers, a group that is neither well studied nor well understood, which is significant because of the cultural chasm that exists not only between low and middle income African Americans but also between middle class White and middle class African American mothers in the US.

6. It supports what is already known about transgenerational dynamics, particularly in African American families, and the importance of considering the role of the African American community in child rearing rather than focusing exclusively on mothers or even parents.

7. It demonstrates the appropriateness of studying distinct populations of various ethnic and socioeconomic groups in order to properly situate their realities into a framework rather than generalizing the experiences of one group and applying it broadly.
8. The study also provides evidence of the fact that eating is a multifaceted endeavor among middle class African Americans and speaks to the importance of designing nuanced and specific strategies for communicating with mothers about human nutrition.

These insights contribute to anthropological knowledge of the infant feeding experience, motherhood in the context of Blackness, motherhood in the context of economics, distinctions between middle class and working class African Americans, and cultural considerations of food value.

This dissertation underscores the unique role that anthropologists can play in community advocacy for ethnic minorities, in helping to reframe the breastfeeding issue from a problem of non-compliance to an issue to lacking family, community and employer supports for breastfeeding and to one that misinterprets the values of African American mothers. The specific call to action outlined above encourages ongoing education of mothers, communities and professionals alike. It specifies the need for a shift from an externally defined gold standard of infant feeding to one defined by and for this community. Finally, it summons the implementation of policies to create the capacity for working mothers to meet the demands of breastfeeding while remaining employed. All of the strategies suggested contribute to the heart of applied anthropology and the improvements to the quality of life and shared knowledge that it seeks to assist. Our understanding of the social meaning of infant feeding is increased by these findings, which ultimately provides insights intended to make the efforts of those who support African American mothers effective and meaningful.
REFERENCES


Groleau D, Rodriguez C. 2009. “Breastfeeding and poverty: negotiating cultural change and symbolic capital in Quebec, Canada.” In Infant and Young Child Feeding: Challenges to

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Are you a medical professional such as midwife, lactation counselor, doula or doctor? Do you work with Black mothers? If so, would you like to participate in a study of Black mothers’ experiences of motherhood?

Contact Airia Papadopoulos for details: asp@usf.edu or call (813) 728-8983

IRB Pro00022339
Appendix B: Flyer for African American Mothers

Are you a Black mother? Are you at least 18 years old? Is your child 5 years old or younger?
If so, would you like to participate in a study of Black mothers’ experiences of motherhood?
Contact Airia Papadopoulos for details: asp@usf.edu or call (813) 728-8983.
IRB Pro00022339
Appendix C: Phase II Interview Tool

Middle Class African American Mothers (MCAM) Experiences of Motherhood During the Infant Stage: Questionnaire for Key Informants

*Interview Number* ______  *Interviewer(s)* ____________________________________________  *Date* ______

**Screening:**
Expert in birth/breastfeeding?  Y
Subject area/job title ____________________________
What populations do you work with? (probe: ethnic, racial, religious groups). Do you work specifically with Black/African American mothers? _____________

For the questions below, please tell us whether you are speaking from first-hand experience, from things you have heard others say, from the scientific literature or general opinion, etc. Thank you.

**Infant feeding values (IFV)**
IFV1. What do you think is (are) most important to Black mothers with newborn babies?
IFV2. How important do you think infant feeding is to these mothers? (probe: how do Black mothers feed their babies and why do you think they do this?)

**Discourages breastfeeding (DBF)**
DBF1. What messages do Black mothers receive about caring for their babies?
DBF2. How do these messages compare to messages for other ethnic groups?

**Influences breastfeeding (IBF)**
IBF1. What (or who) do you think ultimately determines how a Black mother feeds and cares for her child?

**Successful breastfeeding (SB)**
SBF1. What makes a Black mother successful in caring for her baby?
SBF2. How important is infant feeding to being a successful Black mother?
Last. Is there anything else you want to share on these topics?
Appendix D: Phase III Interview Tool

Middle Class African American Mothers (MCAM) Experiences of Motherhood During the Infant Stage: Questionnaire for Mothers

Interview Number _______  Interviewer(s) ____________________________________________  Date _______

Screening:
Ethnicity: Identify as Black/African American and born in the United States? Y
(Must be able to trace family’s history as American and not to other countries.)
Mother’s age: At least 18 years of age? Y Age _____
Child’s age: 5 years of age or younger? Y Age of youngest child _______
Household income: Is your household income at least the amount listed for the size of your household?

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Annual Income</th>
<th>Monthly Income</th>
<th>Household Size</th>
<th>Annual Income</th>
<th>Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$21,775</td>
<td>$1,815</td>
<td>5</td>
<td>$52,559</td>
<td>$4,380</td>
</tr>
<tr>
<td>2</td>
<td>29,471</td>
<td>2,456</td>
<td>6</td>
<td>60,255</td>
<td>5,022</td>
</tr>
<tr>
<td>3</td>
<td>37,167</td>
<td>3,098</td>
<td>7</td>
<td>67,951</td>
<td>5,663</td>
</tr>
<tr>
<td>4</td>
<td>44,863</td>
<td>3,739</td>
<td>8</td>
<td>75,647</td>
<td>6,304</td>
</tr>
</tbody>
</table>

History (HI)
HI1. How far did you get in school?
   ______ Less than a high school diploma
   ______ A high school diploma
   ______ Some college coursework completed or associate’s degree
   ______ Bachelor’s degree
   ______ Master’s degree
   ______ Doctoral degree

HI2. Your age when youngest child was born:

HI3. Do you have other children? Y  N  If so, how many? __________________

HI4. Who lived in your house when your baby was born?

HI5. Were you working when your baby was born? Y  N  If yes, what did you do?
How did your employer respond to your pregnancy?


HI7. Infant feeding: How was your baby fed during the first month after birth (in what amounts)? Was the how you fed your other children, or did you make a change with this baby?

<table>
<thead>
<tr>
<th>Category</th>
<th>Baby Received…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breast milk</td>
<td>Breast milk only from mother/wet nurse/donor</td>
</tr>
<tr>
<td>Predominant breast milk</td>
<td>Breast milk (&gt;75% of diet)</td>
</tr>
<tr>
<td>Mixed feeding</td>
<td>Mix of breast milk and formula (25-75% of diet)</td>
</tr>
<tr>
<td>Predominant formula</td>
<td>Formula (&gt;75% of diet)</td>
</tr>
<tr>
<td>Exclusive formula</td>
<td>Formula only</td>
</tr>
</tbody>
</table>
HI8. Primary caretaker: Who was the primary caretaker for your baby during the first month?

<table>
<thead>
<tr>
<th>Category</th>
<th>Baby Received…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>75% of the time mother fed the infant</td>
</tr>
<tr>
<td>Other caretaker</td>
<td>75% of the time baby was fed by someone besides mother (who was it?)</td>
</tr>
<tr>
<td>Shared</td>
<td>Feeding was shared equally between mother and other caretaker (who?)</td>
</tr>
</tbody>
</table>

Infant feeding values (FV)
FV1. Take me back to when you were pregnant with your baby. Can you describe your life towards the end of your pregnancy? (probes: what did you do? How did you feel [happy, sad, nervous, etc.]? What support did you have?) What mattered most to you just before you had your baby?

FV2. After your baby was born, what was most important about caring for your baby? (Probe: How important was what you fed your baby?)

FV3. What values or dreams do you hold for your child(ren)?

Perceptions/discouragement (PD)
PD1. What makes a good mother? (probes: How does a good mother care for her baby? Does she work or not? Does she bottle feed or breastfeed? What child care issues might she face?) Where did you learn this?

PD2. Are you a good mother? Why do you think this?

PD3. Is being a good mother the same for Black mothers compared with other groups? How so?

External Influences (EI)
EI1. Where did you learn how to care for your baby (probes: family, friends, hospital staff, television, etc.)? What do you know about how you were cared for as a baby (probe: were you breastfed, bottle fed or both? Who raised you? etc.) What (who) do you think influenced how you care for your baby?

EI2. Do you feel others support you in how you care for your baby? How so?

Successful Parenting for Black Mothers (SP)
SP1. What do you think a mother needs in order to be a successful mother?

Last. Is there anything else you want to share?
RE: Expedited Approval for Initial Review
IRB#: Pro00022339
Title: Middle Class Black Mothers’ (MCBM) Experiences of Motherhood During the Infant Feeding Stage

Study Approval Period: 1/17/2017 to 1/17/2018

Dear Mrs. Papadopoulos:

On 1/17/2017, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):

Consent/Assent Document(s)*: Both granted a waiver
SB Verbal Consent Form_Mothers_1.10.2017.docx
SB Verbal Consent Form_Professionals_1.10.2017.docx

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s). Waivers are not stamped.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve
only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. (Verbal Consents).

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D., Chairperson
USF Institutional Review Board